

Staying Alive

COVID-19 and Public Services in West Bengal



Pratichi

Pratichi (India) Trust

Staying Alive

COVID-19 and Public Services in West Bengal

Pratichi Institute

Pratichi (India) Trust

2022

Staying Alive :
COVID-19 and Public Services in West Bengal

Published in June 2022
© Pratichi (India) Trust

Published by
Pratichi Institute, Pratichi (India) Trust
IB14, Sector - III, Salt Lake
Kolkata 700106

Registered Office
Pratichi (India) Trust
A708 Anand Lok, Mayur Vihar - I
Delhi 110091

Cover illustration by
Ranjit Chitrakar

Photo Courtesy
Pratichi Team

Cover Design & Layout by
Tarunkanti Barik

Printed at
Srijani, Kolkata 700056

Contributors

Shiba Aamir
Sabir Ahamed
Susmita Banerjee
Subhra Bhattacharjee
Subhra Das
Antara Dev Sen
Anita Dixit
Dilip Ghosh
Sujata Gupta
Sakila Khatun
Manabi Majumdar
Ankita Mukherjee
Mukhlesur Rahaman Gain
Abdur Rafique
Manabesh Sarkar

Logistical Support

Saumik Mukherjee
Sumanta Paul
Suman Sarkar

Contents

Acknowledgements	....	07
List of Tables	....	08
List of Figures	....	12
Abbreviations	....	13
Summary	....	15
Chapter 1 People's Health during the COVID-19 Pandemic: Public Services and Public Action in Focus	....	29
Chapter 2 Opportunistic Methods of Enquiry	....	47
Chapter 3 Mother Care, Child Care: Disrupted by COVID Care?	....	59
Chapter 4 Health as Security of Food and Livelihood: PDS and NREGS Revisited	....	79
Chapter 5 'No Lockdown for Them': Crucial Role of Frontline Health Workers	....	109
Chapter 6 People's Awareness and Action as a 'Social Vaccine'	....	129
Chapter 7 Care and Un-care of Migrant Workers	....	151
Chapter 8 In Lieu of a Conclusion	....	175
References	....	177
Appendix Tables	....	187

Acknowledgements

This report, since its inception, has been driven by the conceptual guidance and intellectual inspiration that the Pratichi team has received from Professor Amartya Sen, Chairman of Pratichi (India) Trust. As insiders, the members of the team cannot but acknowledge his visionary leadership and direction that they routinely benefit from. The team acknowledges its debt of gratitude to Dr. Anuradha Luther for her immense support to the team during this pandemic-stricken crisis time, both in intellectual and practical terms. This study would not have been possible without a timely and extremely generous grant that this research has received from Mr. Arjun Malhotra, Ms. Kiran Malhotra and Mr. Shiven Malhotra. The team remains hugely indebted to them. We are also very grateful to the Population Foundation of India for its timely support.

Pratichi (India) Trust has been fortunate to have built over the years a network of collaboration with many schoolteachers, health care workers and other civic groups who have come forward to enable the Pratichi team to establish a telephonic bridge with the respondents in this study. The team remains vastly indebted to them for their precious help. Finally, the team expresses its sincerest gratitude to those people who have generously given their time, in the midst of their enlarged burden of labour or unwanted load of leisure, to talk to the members of the team to provide invaluable details of their living realities during the COVID-19 crisis that constitute the nuts and bolts of this report. Any remaining errors remain the responsibility of the research team.

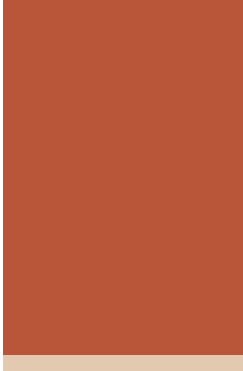
List of Tables

Table 1.1	Degrees of healthcare activism across states: The resilience score
Table 2.1	District-wise distribution of sample for the 'COVID awareness' survey
Table 2.2	District-wise distribution of sample for the PDS and NREGA survey
Table 3.1	Distribution of sample households across districts of West Bengal
Table 3.2	Profile of vulnerability among sample households across districts
Table 3.3	Method of contraception used during April to June, 2019 and 2020 in West Bengal
Table 3.4	Change in RMNCH indicators during the second quarter for last four years in West Bengal
Table 4.1	Distribution of respondents by districts and sectors
Table 4.2	Basic characteristics of respondents
Table 4.3	Entitlement of food grains from PDS by type of ration card
Table 4.4	Distribution of households (percentage) by primary source of income
Table 4.5	Consumption and availability (from PDS) of food grains
Table 4.6	Quantity of food grains received from PDS by type of ration cards
Table 4.7	Purchase of food grains from market by type of ration cards
Table 4.8	Responses on quality of food grains
Table 4.9	Responses on quality of chickpeas
Table 4.10	Distribution of households by impact of the pandemic on income
Table 4.11	Distribution (percentage) of responses about NREGA work
Table 5.1	Average population and average number of villages catered to by health workers during the phase 1 lockdown
Total 5.2	Maternal care during the national lockdown (end March to May 2020)
Table 5.3	Immunization during the national lockdown (end of March to May)
Table 5.4	Home Visits by ASHA workers during the national lockdown (in percent)

Table 5.5	Delivery during the national lockdown
Table 5.6	Supply of face masks
Table 5.7	Supply of hand gloves
Table 5.8	Supply of sanitizers
Table 5.9	Supply of disinfecting agents
Table 5.10	Health workers who purchased protection equipment ever
Table 5.11	Health workers and their COVID-19 related training
Table 5.12	Special incentives for ASHA workers
Table 5.13	Health workers faced harassment while discharging COVID duty
Table 5.14	Health workers faced harassment while discharging COVID duty (social category wise)
Table 5.15	Factors that motivate health workers
Table 6.1a	Rural-Urban distribution of households by the number of living rooms (in percent)
Table 6.1b	Distribution of households by their social category and by the ratio of HH members to the number of living rooms (in percent)
Table 6.2	Knowledge about symptoms of COVID-19 by demographic profile of the respondents (in percent)
Table 6.3	Knowledge of precautionary measures for protection against COVID-19 by demographic background of the respondents (in percent)
Table 6.4a	Distribution of respondents by their perception of problems/dangers associated with SARS-CoV-2 infection by demographic background of the respondents (in percent)
Table 6.4b	Distribution of respondents by their perception of problems/dangers associated with SARS-CoV-2 infection by social category of the respondents (in percent)
Table 6.5	Gap in knowledge and reported practice with respect to three basic public health measures
Table 6.6	Distribution of non-hospitalized cases by type of illness since the lockdown and till the survey (in percent)
Table 6.7	Distribution of non-hospitalized cases of illness by type of facility visited and rural-urban residence
Table 7.1	Some basic information on three selected districts (as per Census 2011)
Table 7.2	Distribution of population by religion in selected districts and survey samples

Table 7.3	Distribution of households by sources of income
Table 7.4	Distribution of migrants by destination
Table 7.5	Distribution of respondents by monthly income slab (Rs)
Table 7.6	Distribution of respondents by monthly expenditure incurred on food
Table 7.7	Distribution of respondents by amount of monthly room rent paid
Table 7.8	Distribution of respondents by expenditure on other necessary things
Table 7.9	Distribution of respondents by the time they took to decide whether to return home
Table 7.10	Distribution of respondents by distance travelled back home on foot/cycle
Table 7.11	Means of transport availed by migrants to return home
Table 7.12	Distribution of respondents according to points of reporting
Table 7.13	Distribution of migrants according to the length of their stay in quarantine centres
Table 7.14	Distribution of households according to their willingness to re-migrate
Table 7.15	Distribution of respondents, unwilling to migrate, by their future plan of livelihoods
Table A.1	Rural Urban distribution of households by access to latrine (in percent)
Table A.2a	Rural Urban distribution of households by access to drinking water (in percent)
Table A.2b	Rural Urban distribution of households by access to water for household activities (in percent)
Table A.3a	Knowledge about symptoms of COVID-19 by social category of the respondents (in percent)
Table A.3b	Knowledge about symptoms of COVID-19 by geographic region of the respondents (in percent)
Table A.3c	Knowledge about symptoms of COVID-19 by religion of the respondents (in percent)
Table A.3d	Knowledge about symptoms of COVID-19 by households' highest educational level of the respondents (in percent)
Table A.4a	Knowledge of precautionary measures for the protection from COVID-19 by social category of the respondents (in percent)

Table A.4b	Knowledge of precautionary measures for the protection from COVID-19 by religion of the respondents (in percent)
Table A.4c	Knowledge of precautionary measures for the protection from COVID-19 by households' highest educational level of the respondents (in percent)
Table A.5	Reported practice of public health measures for the protection from COVID-19 by rural-urban background of the respondents (in percent)
Table A.6	Distribution of persons visited for medical treatment for non-hospitalized cases of illness by type of facility and periods of treatment (in percent)



List of Figures

- Figure 2.1 Rural-urban distribution of sample for the 'COVID awareness' survey
- Figure 3.1 Health facility for delivery and means of transport used by respondents (in percent)
- Figure 3.2 Reasons for choice of facility for delivery
- Figure 3.3 Respondents' education level and choice of facility for delivery (in percent)
- Figure 4.1 Percentage of food-insecure households classified by social groups
- Figure 4.2 District wise reporting of food crisis
- Figure 4.3 Source of income as a determinant of relative food insecurity
- Figure 4.4 Household food shortage by the category of ration cards
- Figure 4.5 Percentage of households that received food grains from non-governmental agencies and activists
- Figure 4.6 Food consumption pattern of food-insecure households (n=97)
- Figure 4.7 Proportions of households driven to sale/mortgage of valuables in response to the crisis
- Figure 4.8 Caste-wise distribution of households reporting income losses
- Figure 4.9 Percentage distribution of households by job-cards
- Figure 4.10 Employment opportunities for job-card holding households
- Figure 4.11 Average number of person-days of employment created across districts
- Figure 4.12 District-wise proportion (%) of households that received employment
- Figure 5.1 Services of sub-centres during phase 1 lockdown
- Figure 6.1 Respondents' knowledge about symptoms of COVID-19 (in percent)
- Figure 6.2 Knowledge of precautionary measures for protection from COVID-19 (in percent)
- Figure 6.3 Distribution of persons by their reason for choice of health facility and by type of health facility (in percent)
- Figure 7.1 Distribution of migrants by age group
- Figure 7.2 Distribution of respondents by level of education
- Figure 7.3 Distribution of respondents by relation with their household heads

Abbreviations

AAY	Antodaya Anna Yojana
ANC	Antenatal care
ANM	Auxiliary Nurse Midwife
APL	Above Poverty Line
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BCG	Bacillus Calmette-Guerin
BPL	Below Poverty Line
FPS	Fair Price Shop
GHI	Global Hunger Index
GoI	Government of India
GoWB	Government of West Bengal
HH	Household
HMIS	Health Management Information System
ICDS	Integrated Child Development Services
IMR	Infant Mortality Rate
IRCTC	Indian Railway Catering and Tourism Corporation
MGNREGA	Mahatma National Rural Employment Guarantee Act
MMR	Maternal Mortality Ratio
NFHS	National Family Health Survey
NFSA	National Food Security Act, 2013
NREGA	National Rural Employment Guarantee Act
NREGS	National Rural Employment Guarantee Scheme
NRHM	National Rural Health Mission
NSS	National Sample Survey
OBC	Other Backward Communities
PDS	Public Distribution System
PHH	Priority Household

PMAY(G)	Pradhan Mantri Awas Yojana (Grameen)
PPE	Personal Protective Equipment
RKSY	Rajya Khadya Suraksha Yojana
RMNCH	Reproductive, Maternal, and Newborn Child Health
SARS-CoV-2	Severe Acute Respiratory Syndrome Corona Virus - 2
SC	Scheduled Caste
SDG	Sustainable Development Goal
SPHH	Priority Household with Sugar
ST	Scheduled Tribe
TT	Tetanus Toxoid
UHC	Universal Health Coverage
UMP	Unqualified Medical Practitioner
WHO	World Health Organization

Summary

Focus

This is the time of 'epidemiological vulnerability', triggered by a pandemic. This is also the time when human insecurities and basic capability deprivations that large sections of the population in different parts of India suffer from in the 'normal' times get amplified manifold. However, whether this 'crisis' time invariably accentuates pre-existing sufferings of vulnerable populations i.e. 'the frontline victims', to use Amartya Sen's poignant phrase- or energizes public policies and social actions to mitigate, not exacerbate, their woes is the central question that motivates this study.

Importantly, how a society and a political regime – at the centre or in the states – have chosen to respond to the current challenge is a matter and a manner that is widely divergent across the regions of the same national universe of India, indicating that India is differently democratic, differently 'civic-minded', and differently 'public-facing'. This variability in pandemic responses within the Indian union gives us a cause for measured optimism about the possibility of social solidarity and coordination as well as concerted governmental action to push through various measures and public services – old and new – even in the face of severe constraints. To put it differently, variable state responses confirm that the crisis time demands and leaves room for a social attention-view, rather than a purely individual responsibility-view, of human empowerment.

The focus of this report, however, is not pitched directly on the multi-faceted management and treatment of the COVID-19 virus in the country per se, and the related policies and processes of vaccination of the population against this contagion. Keeping this catalytic and active bio-medical phenomenon as an essential backdrop, we centre the role of certain key public services to see and value the power of collective efforts in general and the importance of social policies i.e. the 'safety net' in particular to cope with a disaster such as the COVID-19

pandemic. The disruption or stoppage in these essential services has a bearing on people's health and livelihoods, and on their basic capabilities, so profoundly and so long-term a way as to perilously transform an epidemiological crisis into a huge socio-economic pandemic. Thus, it is not the presence or size of the social delivery system per se but its fragility or robustness in providing protection against a pandemic that constitutes the object of the present enquiry.

In more concrete terms, this study, with an empirical focus on the state of West Bengal, examines the vim and vigour, in lockdown and post-lockdown periods, of the child immunization programme and of antenatal/postnatal care of pregnant women, as well as the programmes of public distribution of essential food supply and of rural employment guarantee.

Also of particular interest is to offer in this study a grounded analysis of the role of frontline healthcare workers in mitigating the ill-fare of 'frontline victims' throughout the crisis, practically stepping into the shoes of the 'barefoot' public health cadre, transcending their assigned regular duties merely as community health workers.

This report also seeks to ascertain people's awareness about the risks associated with the COVID-19 infection, their knowledge of its effective mitigation, and their own behavioural changes, if any, that may have performed the role of a 'social vaccine', over and above a biomedical vaccine.

Finally, one of the poignant instances of coping with this crisis has been exemplified by the struggles that migrant workers have had to put up with during and after the lockdown periods. This too is a form of public activism, in terms of both common hardship and collective effort, as well as of governmental action or inaction.

This study has collected primary data over the phone, from West Bengal, during the months between July-December, 2020, and with some pauses, in the first few months of 2021. A little over 2000 households have participated in this survey.

Highlights

Mother Care, Child Care in the season of COVID Care

The major impact was on frontline healthcare workers, who were engaged in various COVID-related activities and therefore often unavailable to fulfil their primary responsibilities in the maternal and childcare sector. Our field study indicated that in three-fourths of the cases, the ASHAs had not visited the expectant/lactating mother during the lockdown; however, they have played a more positive role in institutional delivery. About 59 percent of the respondents received support from the ASHA for delivery. Most respondents did say that the ASHA workers made telephonic enquiries during the lockdown about whether any household members have COVID symptoms, or dengue/malaria. Post lockdown, personal visits from the ASHA increased substantially to about 86 percent, but the increase in the proportion of ASHAs providing support for institutional delivery increased only marginally to about 61 percent.

Reports of disruptions in pregnancy registration and other ante-natal and post-natal care notwithstanding, in our field survey which began in July 2020, we did not find many signs of systemic lacunae arising from the pandemic and the lockdown. It appears that there was adequate awareness of the need to get pregnancy confirmed and to register for delivery; most respondents in our study stated that they had got the pregnancy confirmed in time and the registration was also done in time. Over all the districts, the system for institutional delivery appears to have functioned fairly well during the lockdown. Of all the mothers we interviewed, we found only two cases where the child had been delivered at home, and only 3 percent of all respondents stated that they had faced refusal from government or private institutional sources for delivery. Several of the respondents, however, described difficulties in getting a vehicle to transport the expectant mother to the healthcare facility for delivery.

The figures state that slightly more than half of the respondents used the government transportation, *Nischay Yan*, to move to the place of delivery. However, more than 30 percent also used private vehicles such as rental cars.

Child immunization appears, from our respondents, to have functioned relatively smoothly, when other studies have indicated a downturn in vaccination in the

same period. However, many respondents' information about the vaccination schedule depended on what the healthcare functionaries said, thus alerting us to the limitations of perception-based responses. Many of them responded that all inoculations had been done in time, but on enquiring which of the vaccines were due, very rarely were they able to explain the schedule.

In several cases, vaccination that was due during the lockdown period was taken during the 'unlock' period, while the vaccination to be done during the unlock period was still due.

Security of Food and Livelihood: PDS and NREGS in Focus

According to the findings of this study, one out of five households faced some food crisis. The duration of crisis varied between 4 and 240 days. A majority of these households suffered for about 60 days. When social groups are taken into account, reporting of food crisis by Scheduled Tribes was higher than that by any other social group. Association with underdeveloped agriculture, petty non-agricultural activities and migration seemed to have played a role in this regard. In the so-called normal times, poor income from cultivation could have been supplemented by non-agricultural activities and seasonal migration; but both these avenues got restricted during the lockdown period.

The households that reported food shortage the most (29%) were those whose primary source of income was hiring out labour for agricultural activities. This is followed by those that eke out a living by hiring out labour for non-agricultural activities (25%).

Suffering from food crisis was not uniform across the districts. The highest affliction was reported from Purulia (47.5%) followed by Bankura (35%).

The proportion of food-starved households would have been higher, in the absence of free distribution of food grains. To mitigate such conditions, free food grains were distributed by ICDS centres, schools, philanthropic organizations and individuals; but an augmented PDS was the most important intervention in this respect that provided larger quantity of food grains, with an almost universal coverage.

The poorest category (i.e. AAY card holders), didn't report of any suffering from food shortage. A possible reason behind this may include the fact that the quantity of food grains they received under PDS was the highest. Public provisioning of food support for this category of card holders was the highest among all types of beneficiaries.

On the other hand, the households having no valid (NFSA and RKSY category) ration cards reported to have suffered the most (36%). In other words, the public food safety net turned out to be a critical element to avert hunger and starvation during this COVID-triggered pandemic.

The coverage of population of the state by the scheme sponsored by the central government (NFSA) was noticeably lower (57%) as against its target (67%). The initiative of the Government of West Bengal to cover rest of its population under the PDS through another set of cards proved crucial. Provision of ad-hoc benefit of free food grains was also made through a coupon system for those who were yet to get ration cards or needed it in any case.

Employment under NREGA was supposed to serve as another source of mitigating food and nutrition crisis via access to some money, against the backdrop of the jobless growth of the pandemic. It appeared from the present study that the COVID pandemic caused income loss for 87.8 percent of the participating households in various ways.

Among the job-card holding households only 55 percent reported that they got some employment. This means quite a large proportion of households (45%) did not get any employment.

On an average a household having a member with a job-card got 23 days of employment during the period between April and December 2020. This seems to be unsatisfactory performance particularly when employment opportunity in the open labour market was meagre due to the COVID-19 crisis. This stood out in contrast to the past performance of the state with respect to creation of employment days. Against the national average of 50.9 days a year, West Bengal created more than 77 days of employment during 2018-19 (Government of India, 2021).

Uneven creation of employment days across districts was also noticed. While all the respondents of Coochbehar reported that they worked under NREGA, the corresponding figure was only five percent in Uttar Dinajpur (n=40 in both the districts).

It needs underlining however, that several scholarly studies report significant wage payment delays caused by delayed transfer of the same by the Central government. During most part of the period under review, such delays have been recorded in a significant number of cases for the state of West Bengal, possibly signifying that the observed decline in employment days under the NREGA in recent times is a consequence of insufficient fund transfers. While during 2018-19 most states lagged behind West Bengal in terms of generation of employment days under the NREGA, whether the employment protection in this state has also been more robust in crisis times than in the rest of India is difficult to establish due to the paucity of comparable data.

'No Lockdown for Them': Frontline Health Workers

The pandemic and the subsequent lockdown have brought to light the importance of health workers (ASHAs, ANMs) as the front line actors in the fight against the Corona virus.

During the national lockdown, the work of ASHAs included conducting door-to-door health surveys to identify chronic diseases (like hyper tension, diabetes, kidney or heart related ailments etc.), carry out community awareness campaigns, identify COVID patients and test them. Their work also included maintaining quarantine and isolation centres, as well as following up on whereabouts of migrants. Their assigned outreach significantly expanded during the pandemic time. Our primary survey indicates that they were covering close to twice the population they are supposed to cater to during these difficult times; one ASHA served, on an average, 1898 people.

During the long stretch of the lockdown, our study found that the working hours of ASHAs extended to 13 hrs. During the first week of June 2021, as essential health services started re-opening, the burden of work became onerous for

ASHAs and ANMs, as they had to make up for the backlog in immunization created in the preceding three months of lockdown. They had to resume and even boost up full vaccination drives and out-reach programmes which were partially halted due to the lockdown.

Disruption in essential services and expansion of Covid duties were reported by the respondents. In the initial days of the national lockdown, our survey found that in 50 percent of cases, sub centre services were disrupted during the lockdown. In 52 cases out of 158 (32.9 percent of the sub-centres under review) there was disruption of maternal care services and 99 of the said sub-centres (62.7 percent) discontinued their vaccination services. This was primarily because ASHA workers were engaged in a host of other COVID prevention activities like contact tracing, surveillance etc. It needs underlining, therefore, that there was no lockdown for this workforce, and no respite from, and only proliferation of, their arduous load of work.

Even in such bleak times, ASHA workers could ensure 96.7 percent institutionalised deliveries (1176 out of 1216) from end-March to May 2020.

ASHA workers are trained to work as frontline line health workers mainly as members of a community outreach programme, yet they were deployed to practically step into the shoes of public health staff in position in the temporary quarantine centres set up for the migrant labourers.

What motivated them to carry on against all odds? The government considers them as mere 'volunteers'. But they choose to work and have chosen to work with full dedication in this crisis time. Being an ASHA worker helped them perceive the value of life differently. In our study it was seen that 70.7 percent of health workers considered this as their 'duty' and not as just volunteer work.

People's Awareness and Pandemic Responses as a 'Social Vaccine'

Scientific knowledge about SARS-CoV-2 is still inadequate to deal with the virus effectively. Inadequate health infrastructure and pre-existing socio-economic vulnerabilities of large sections of its population have added to these shortfalls and correspondingly made the remedial responses that much more challenging. For

example, the pre-existing housing and hygiene vulnerability of a large section of the populace certainly shapes and limits their behavioural choices. As one of the worst hit states in India in terms of the availability of space, 34 percent of the rural households and 31 percent of the urban households in West Bengal did not have any separate room for the married couples according to a survey in 2018. As per our survey, 33 percent of the sample households in West Bengal had only one room to sleep in for all the household members, indicating the huge challenge to follow public health measures of physical distancing or self-quarantine/isolation.

Unavailability of adequate water for washing hands several times a day with soap is another area of concern that constrains people from observing the Corona hygiene guidelines. While the problem of insufficiency of water does not appear very serious in sample households during our survey, it is difficult to follow the WHO advice for frequent hand wash with soap.

However, the signs of a so-called 'social vaccine', i.e., people's knowledge and information about COVID-19 risk mitigation- have been encouraging in several parts of the state. The rigorous public campaign launched to make people aware of the disease and of the precautionary measures essential for protection yielded some good results in terms of knowledge creation. We find that 89 percent of the respondents in our survey were aware of two common symptoms of COVID-19 viz. fever and cough. As high as 92 percent knew that fever was a common correlate of this disease. However, their awareness about the symptom of breathlessness which was critical to assess the need for hospitalization was uneven. We find that 50 percent of the rural respondents were unaware of it, while the corresponding figure was 30 percent for the urban respondents.

As in the case of knowledge about symptoms, the knowledge of essential public health norms was also found to be an outcome of the public campaigns that were conducted to spread awareness among people about the deadly disease. Most of the respondents in our survey were found to be aware of the critical role of wearing masks (97%) and hand washing with soap or sanitizers (90%). A sizable majority (68%) was aware of the public health norm of maintaining a physical distance of 3/6 ft. In brief, the three basic public health norms that are thought to be necessary behavioural practices for the people to follow for their own protection from the

disease were known to a majority of the people in West Bengal. A negligible proportion of respondents (1%) were unaware of any precautionary measures.

Overall, it may be argued that as a result of vigorous public campaigns launched by the state and other agencies, the people of West Bengal largely became aware of the symptoms of COVID-19 and of the precautionary measures essential for protection from this disease. Whether people's behavioural practices measured up to their knowledge base was the next question that we probed. However, given the inherent limitations of a telephone survey, it has not been possible for us to observe face-to-face the extent of people's compliance with the various safety norms. Indirect evidence about inconsistent mask-wearing among several sections of the population, and their inability or un-enthusiasm to maintain physical distancing cannot, however, be ignored altogether. Arguably, knowledge has not necessarily led to responsible action on the part of the masses, especially given the glaring examples of non-compliant behaviour of several political leaders themselves. Also, the social and other vulnerabilities of the people contributed a lot towards their seeming non-compliance. For example, a non-agricultural casual labourer from Alipurduar district informed us that he could not follow the safety norms properly as he had no option but to go out and work. Still our survey indicates that the respondents at least felt inclined to project themselves as rule-bound and norm-bound individuals, behaving as socially responsible actors. Only a small proportion of the respondents stated that they were not following the basic norms of wearing masks or hand hygiene despite having knowledge about it.

People's health seeking behaviour for non-COVID diseases, however, reveals a complex picture of intersecting constraints, including those of deficiencies in public health infrastructure, and hesitancy on the part of the people to seek treatment during the pandemic. Nevertheless, on balance, one may contend that although the pandemic or the lockdown compelled some people to compromise with the quality of care or to stop ongoing treatment altogether, the people in West Bengal in general received treatment for their non-COVID diseases despite the presence of grave risks associated with the outbreak of COVID-19.

During the first wave of the pandemic, treatment available for non-COVID diseases remained relatively undisturbed in rural areas in the state, as the spread of

COVID-19 remained confined to urban areas mainly in that phase of the pandemic. Even in urban areas the health care services for non-COVID diseases didn't collapse altogether in the first wave, though it was a real possibility. Hence, we find that on balance the people in West Bengal somehow managed to avail treatment for their ailments during lockdown and unlock days in the first wave of COVID-19, though somewhat compromising with the quality of care in some cases.

The proportion of respondents who visited government facilities i.e. either a Primary Health Centre or a Corporation Health Centre or any Government or Public Hospital for their non-hospitalized illness, was 19 percent. More than one-fourth (26%) of the non-hospitalized cases were found to be treated by the private allopathic doctors at their chambers or clinics or hospitals. If we add to it the proportions of 'private telemedicine' and private homeopathic care, it increases to 33 percent. As per our survey 30 percent of outpatient care in rural areas was sought from Unqualified Medical Practitioners (UMPs). The study surmises that as a result of the pandemic, reliance on private doctors in urban areas has been partly replaced by self medication on the part of the people, as also by reliance on the advice of medical stores, resulting in a noticeable proportion of self medication (22%).

Looking at the reported motivation of the people for choosing the health facility they chose for out-patient care, we find that majority of those preferring government facility chose it for their inability to afford private allopathic doctors sitting at chambers or clinics or hospitals (39%). But to a substantial proportion (28%), the motive force for preferring government facility was the credibility of the government facility to provide service even during the pandemic.

Importantly, the study finds a variation in the pattern of health seeking behaviour of people during the lockdown and the 'unlock' period. While the relatively small sample size of care seekers during the lockdown period in our survey prevents us from making a very emphatic and definitive claim in this respect, the study makes a qualified statement. While the proportion of people visiting government facilities during the lockdown was higher than that post lockdown, the reverse trend was seen for the private allopathic doctors. In other words, the proportion of

people visiting private allopathic doctors during the lockdown was lower than that in the 'unlock' period. The trend for UMPs was found to be similar. This leads us to infer that it is the public health care service, albeit less-than-ideal, that kept the hope of the people alive for getting a modicum of medical treatment during the initial phase of the pandemic, as the private players made themselves scarce during the national lockdown, leaving the healthcare market dormant and inactive at a time when the need for action was acute.

Care and Un-care of Migrant Workers

The issue of labour migration in India should have been paid serious attention at the time of announcement of the lockdown on March 24, 2020. Noticing official neglect and inattention to such a momentous issue, the Supreme Court of India issued orders for the governments to pay due attention, particularly to their access to food, accommodation and their travel back home. Against this backdrop, the present study offers a snapshot view of the lives of migrant workers returning to West Bengal, after the announcement of the national lockdown, focusing particularly on the nature of challenges they faced and support they received from various stakeholders.

Almost all of the migrants (92%) in the sample earned their livelihoods by hiring out labour, indicating that they come from a poor economic background. Significantly, 74.8 percent respondents were the main earners in the family. There were 18 states from where the migrants headed home. Most of the returning migrants (61.2%) were from the southern states. The highest proportion of migrants worked as masons or their helpers.

The study finds that an overwhelming proportion (93.2%) of the migrants lost their employment due to the lockdown. But the challenges they faced were not limited only to employment losses in the destination, but also pertained to their arduous return journey as well as what they experienced in the source area upon their return.

Only 13.4 percent migrants returned home within 10 days since the lockdown. Some (5.8%) stayed in the destination for more than ninety days. More than 50

percent of them returned after May 1, 2020, when the *Shramik Special* train began to run.

It is difficult to imagine the misery of the migrants, who lost their employment and so income, but could not avoid essential expenditure for themselves particularly on food, shelter and some other necessary items, at the destination, and for their left-behind families at source. In the destination, migrants were not entitled to have access to existing social security schemes like the PDS (one nation, one ration card was yet to be operational, at the time of completing this report).

Some support for food and accommodation in the destination during the lockdown was received by 32.6 and 39 percent of the migrants respectively. Cash support from employers was received by only 3.8 percent of the respondents.

Eight percent of the returnee migrants travelled, in part or through the entire journey, on foot or by bicycle. The longest distances travelled by the migrants by bicycle and on foot were 700 km and 250 km respectively. Bus and train were means of transport for 46.2 and 50.2 percent of the returnee migrants. Of those who travelled by train, only 22.6 percent got a free ride. Such arrangements were made mainly by government agencies including the Government of West Bengal. Others had to pay for transport somewhere between Rs.2500 and Rs. 10000. During their return journey food support was made available to a significant number of migrants.

A little over 26 percent of returnee migrants reported that they were contacted by authorities of the Government of West Bengal or by any non-government agencies (NGOs) for the purpose of their return. In most of such cases it was from the end of the government.

Their experience of journey back home was mixed. Nine percent of the migrants faced some sort of harassment which was caused mainly by police or some other public authority. Evidence of good treatment meted out by the police was also available.

The issue of labour migration needs to be carefully addressed in the light of the tremendous hardship that this largely ignored and invisibilized section of the country's labouring class has had to undergo during the national lockdown. That

the policy responses to contain the bio-medical pandemic caused a kind of socio-economic pandemic for this section of our citizenry is a lesson that a democratic India cannot afford to overlook.

The Time for Public Action against Shared Predicaments

Of the many insights that we have gleaned from this study about governmental and other collective responses to the pandemic-generated social injuries that have particularly dented the lives and life-chances of the masses, we only reaffirm two here that encapsulate the spirit of several others. First, the longstanding, well-considered, but oft-flouted vision about the critical role of public institutions and services in empowering people with basic capabilities has come to its full relief during the pandemic. People seem to have rediscovered that public schools matter, tax-financed universal basic healthcare matters equally if not more, that the public health system and its cadre need to be strengthened manifold, and that public guarantee of basic food and livelihood security are the essential correlates of decent living in all seasons – pandemic or endemic.

Second, the findings of this study have resonated with the perceptive comment that Professor Amartya Sen has made about viewing the crisis time as a period and occasion of collective endeavour to combat shared predicaments. Surely, there have been failures, oversights, and instances of cruel indifference vis-a-vis people's woes, as also of institutional inertia and deficiencies in coming up with responses and resources that could have better secured people's basic entitlements during these extraordinary times. But, on balance, we have noticed an assertion of a social ambition to stand in solidarity with others; this affirms the public-spirited outlook that informs this report.



Digging for drainage under the NREGS during the pandemic

People's Health during the COVID-19 Pandemic: Public Services and Public Action in Focus

CHAPTER 1

This is the time of 'epidemiological vulnerability', triggered by a pandemic. This is also the time when human insecurities and basic capability deprivations that large sections of the population in different parts of India suffer from in the 'normal' times get amplified manifold. However, whether this 'crisis' time invariably accentuates pre-existing sufferings of vulnerable populations i.e. 'the frontline victims', to use Amartya Sen's poignant phrase- or gives rise to public policies and social actions that work to mitigate, not exacerbate, their woes is the central question that motivates this study.

Importantly, how a society and a political regime at the centre or in the states- have chosen to respond to the current challenge is a matter and a manner that is widely divergent across the regions of the same national universe of India, indicating that India is differently democratic, differently 'civic-minded', and differently 'public-facing'. This variability in pandemic responses within the Indian union gives us a cause for, not just despair, but measured optimism, about the possibility of social solidarity and coordination as well as concerted governmental action to push through various measures and public services – old and new – even in the face of severe constraints.

Encouragingly, several studies and reports are already available that focus on various dimensions of pandemic responses that have come up in different parts of the country during both lockdown and post-lockdown periods. This report draws on a number of key insights from several of these studies. The focus of this report, however, is not pitched directly on the multi-faceted management and treatment of the COVID-19 virus in the country per se, and the related policies and processes of vaccination of the population against this contagion.

Keeping this catalytic and active bio-medical phenomenon as an essential backdrop, we fix our gaze on some of the core public services – for example, primary healthcare for the mother and the child, food and work security schemes

for marginalized sections of the population, basic entitlements of a large body of informal and 'footloose' workers who migrate to eke out a living, and so on – that a government in times of the pandemic has kept providing partially or haltingly or has largely failed to do so. The stoppage or disruption in these essential services has a bearing on people's health and livelihoods, and on their basic capabilities, so profoundly and so long-term a way as to perilously transform an epidemiological crisis into a huge socio-economic pandemic. Thus, it is not the presence or size of the social delivery system per se but its fragility or robustness in providing protection against a pandemic that constitutes the object of the present enquiry.

Why Centre the Role of Public Services?

There is a line of thinking, encapsulated in the doctrine of 'Disaster Capitalism', which forcefully suggests that market forces thrive on and take advantage of the 'shock' that disasters – either natural or man-made – produce and deviously introduce for-profit rather than public-regarding policies (Klein 2007). These concerns seem real when one takes cognizance of the fact, as revealed in a World Bank report, that during the pandemic while India's stock markets have boomed and the very rich have increased their wealth, the number of poor people in the country (with income of \$2 or less) has increased by 75 million (as quoted in Maira 2021). There is indeed a 'pre-existing pandemic of poverty' (Human Rights Council 2020, also see Sumner, Ortiz-Juarez and Hoy 2020) in the country that has visibly worsened during the current crisis, further exacerbated by the deepening of extant socio-economic inequalities.

In this twilight of human and political unfreedoms and the overwhelming private burden to cope single-handedly with the huge challenges thrown up by the pandemic, an alternative possibility is, however, imaginable and indeed emergent that has been pithily described by Bunch (2020) as 'disaster socialism'. The central message that the author wants to convey through this coinage is to see and value the role and power of collective efforts in general and the importance of social policies – i.e. the 'safety net' – in particular to cope with a disaster such as the COVID-19 pandemic.

To embellish this argument, we draw on the deep insights that are already available in the writings and thoughts of Professor Amartya Sen about a disaster being a time to forge networks of social alliance for public as well as governmental action, with aims to provide social protection against private predicaments. Citing Sen's example of World War II Britain, we quote him, "there was a fear that there would not be enough food and that people would starve. So the policy of rationing and of controlled prices was implemented. As a result, not only was starvation averted, but undernourishment declined greatly, and severe undernourishment disappeared altogether." It took the war, to quote Sen again, "to make the British government take on the responsibility of feeding the entire British population—though this did not extend to its colonial subjects in India, where there was a major famine during the war years." (as quoted in Palaiologos 2020). The crisis time, therefore, demands and leaves room for a social attention-view, rather than a purely individual responsibility-view, of human empowerment.

People's Health in Focus

This study is on people's health in a pandemic era, energized or enervated through public provisioning or its lack. It uses, as its starting point, the capability approach to human development, as developed by Professor Amartya Sen (1993, 1999). Within this conceptual framework, basic health is viewed as one of the core human capabilities, and correspondingly, healthcare as a social commitment rather than as a purely private burden. It is because of this public-facing nature of this perspective and of its expansive definition of what good health entails and requires that it focuses on the functioning of a few basic public programmes and services that have a major bearing on public health or its deprivation, in both normal and crisis times.

In more concrete terms, this study examines the vim and vigour, in lockdown and post-lockdown periods, of the child immunization programme and of antenatal care of pregnant women, the programmes of public distribution of essential food supply and of rural employment guarantee. Taken together, these schemes and their operation – smooth or faltering – are expected to inform us about the extent to which public in/action has either exacerbated or ameliorated the scourge of

health inequalities that beset most parts of our national universe even in normal times.

Also of particular interest is to offer in this study a grounded analysis of the role of frontline healthcare workers in mitigating the ill-fare of 'frontline victims' throughout the crisis, practically stepping into the shoes of the 'barefoot' public health cadre transcending their assigned regular duties merely as community health workers. In other words, healthcare activism, even under most perilous conditions, on the part of many frontline healthcare workers constitutes a focal part of the present enquiry.

The focus in this study on public institutions is also complemented by a parallel scrutiny of the level of public awareness about the nature of this pandemic and about measures of protection against the same. Such awareness or its lack, the study argues, will give us an idea of citizen's activism or its absence vis-à-vis the deadly virus. Thus viewed from the standpoint of the public, this report seeks to ascertain people's awareness about the risks associated with the COVID-19 infection, their knowledge of its effective mitigation, and their own behavioural changes, if any, that may have performed the role of a 'social vaccine' (John and Seshadri 2020) over and above a biomedical vaccine.

Finally, one of the poignant instances of coping with this crisis has been exemplified by the struggles that migrant workers have had to put up with during and after the lockdown periods. This too is a form of public activism, in terms of both common hardship and collective effort, as well as of governmental action or inaction.

As has been elaborated in the next chapter on our methods of enquiry, this study has collected primary data over the phone, from West Bengal, during the months between July-December, 2020, and with some breaks, in the first few months of 2021. A little over 2000 households have participated in this survey. Since the sample size is decent by standard statistical measures, the findings that are drawn from this study are likely to add value to other available works on this subject. Also, to the best of our knowledge, no other studies of this nature, and drawing on primary data, are available in West Bengal as yet.

*Variable State Responses as a Basis for 'Possibilism'*¹

As indicated earlier, it is within a social field of engagement and efforts- possible though not inevitable in the pandemic hour- that we seek to embed our analysis of the functioning of a few essential public services in the state of West Bengal, during the lockdown and post-lockdown periods. Admittedly, basic public health services and social protection policies in many states of India are woefully inadequate; even these meagre public services and the understaffed health workforce have been diverted to fight Corona, resulting in reduction, disruption, or total stoppage in routine health services as well as in basic food and work security schemes during the national lockdown. This has had a life-changing consequence for those who depend on them (Aman et al 2021)

Such shortages and stoppages notwithstanding, there has been a recovery of routine health services in most states after the lockdown (Dreze and Paikra 2020). More importantly, the authors insightfully argue and demonstrate that even during the lockdown the 'decline' in health services has been highly 'uneven' between states. This variability in the vim and vigour of the social protection system across the states of India under extremely difficult circumstances creates a 'bias for hope' (Hirschman 1971) and for public choice in favour of social justice even under constraints, subject of course to the possibility of fulfilment – at the central and state levels – of some crucial enabling conditions such as a democratic framework of policy-making.

Collating data available on Government of India's Health Management Information System (HMIS) on a few crucial health services such as antenatal care of pregnant women and child immunization, in lockdown and pre-lockdown months, Dreze and Paikra (2020) make a bold claim, 'The sharp contrast between the usual "leaders and laggards" of social policy highlights the fact that decline in health services during the national lockdown was largely avoidable...The disruption has been highly uneven between states....states with a relatively good record of commitment to health care continued to provide basic services during the lockdown to a large extent. Others allowed health services to come to a virtual standstill. In other words, the collapse of health services during the lockdown was far from inevitable.'

¹ This is a coinage by Albert Hirschman; See Hirschman (1971).

This evidence-backed assertion protects us from developing a 'failure complex'; it also prompts us to see how some states in the Indian union continue to make a significant difference to people's lives during these circumstances through social policies while others need to step up their policy activism to a considerable extent in order to do so. This is what motivates this study to centre the role of core public services in the on-going pandemic discourse. We echo the sentiment of Philip Alston (2019) who emphatically states, 'The time has come to take social protection seriously'.

Introducing the Focal Themes of This Report

Basic Care for the Mother and the Child: Interruptions in the Pandemic Season

The nutritional security of the mother and the child in large parts of the country is already very fragile, as a result malnutrition is endemic in India (Raghunathan, Headey and Herforth 2020). The authors find that in 2015-16 '...38% of preschool children were stunted and 21% were wasted, while more than half of Indian mothers and children were anaemic.' What is also disconcertingly pan-Indian, as the authors vividly demonstrate by looking at minimum wages and food prices through the 'nutritional lens', is that nutritious diets are often highly unaffordable for the poor, particularly in rural areas. In this context of acute private predicament, public programmes such as supplementary nutrition programmes and cooked meals under the Integrated Child Development Services (ICDS) and elementary education programmes are run in the 'normal' times. To what degrees these essential services have been disrupted in the pandemic season – in both lockdown and post-lockdown months – across the Indian states, causing what degrees of additional nutritional losses are questions as important to address as the management of the COVID-19 virus.

Furthermore, decades of efforts to launch and run immunization programmes to protect children against avoidable diseases and mortalities and the positive outcomes that have ensued seem to now encounter serious threats of reversals, due to pandemic-induced disruptions and stoppages therein. Similarly, basic antenatal care for pregnant women, including regular monitoring of their weight and blood pressure, timely health checkups, as well as provisioning of essential

medicines and treatment required during pregnancy, has been amiss in varying degrees across the country (Bhattacharya 2020). At the very least, it is necessary to probe the scale of these interruptions in the wake of the COVID-19 pandemic that appear to be larger than what was estimated initially (Rukmini 2021). Drawing on new official data, Rukmini suggests that April 2020 saw a higher fall in immunizations and maternal health interventions than in March 2020. In her words, 'Fewer women accessed maternal healthcare in March and April 2020, when the lockdown was at its strictest....Routine checks on pregnant women and tests that are vital for the health of the mother and child were missed, and the number of institutional deliveries fell; there were over 580,000 fewer institutional deliveries in April than in January, which could indicate that many more women had potentially unsafe deliveries at home'. Though signs of revival in some service indicators were emergent in May and June 2020, disruptions and delays no doubt have long-term effects on health.

Dreze and Paikra (2020) make a powerful argument about the varying degrees of disruptions and declines in basic health services that have occurred during the national lockdown in the country by carefully sifting through Government of India (GoI)'s data available on HMIS with respect to a number of health indicators such as a) the number of pregnant women registered for antenatal care (ANC), b) institutional deliveries, and c) child immunization (BCG). Their inter-state comparisons draw our attention to an important reality that India has responded differently to the basic healthcare needs of the people even during the lockdown period, thereby suggesting what governmental action could be possible in the face of the stringent lockdown-induced constraints. In Table 1.1, we reproduce one of the indicators of resilience, during the lockdown, of the three health services, namely, ANC registration, institutional deliveries and child immunisation, that they have imaginatively calculated, by comparing April-May 2020 average as a proportion of January-February 2020 average across states. From the cluster of states that we have chosen selectively from the larger set presented in Dreze and Paikra (2020), we notice varying degrees of resilience of governmental action in these respects in the lockdown months. To put more elaborately, during this period, a group of Indian states seem to be decently active in their healthcare provisioning; the second cluster consists of middle order

performers, while the third represents states that have remained relatively inert and inactive in discharging their healthcare responsibilities during the same period. This helps us to question the so-called TINA (There Is No Alternative) mentality about the unavoidability of decline in services during the lockdown.

Table 1.1: Degrees of healthcare activism across states: The resilience score

	ANC	Institutional Deliveries	BCG
India	78.1	71.3	65.0
Active states			
Telangana	105.7	94.9	101.5
Odisha	110.0	91.7	96.2
Kerala	102.0	112.5	108.2
T.N.	107.7	86.2	98.3
H.P.	105.7	87.8	88.1
Middle-order activism			
Maharashtra	94.0	74.4	86.6
Rajasthan	88.9	79.6	70.3
A.P.	95.0	72.5	76.7
M.P.	92.7	80.3	73.8
W.B.	90.6	79.7	71.7
Relatively inert states			
Gujarat	94.6	63.6	64.0
Assam	108.6	60.2	57.8
Jharkhand	68.5	74.4	56.1
Bihar	65.5	52.7	52.6

Source: Dreze and Paikra (2020)

This, of course, has an obvious connection with the resilience or otherwise of the universal healthcare system in the country as well as of the other critical nutrition programmes, along with the associated issues of budgetary allocations. As Kumar (2020) reminds us in the context of the pandemic, '....this is the time to seize the opportunity and invest in Universal Health Coverage (UHC), by reversing the financial neglect of public health care. Nearly every country in the world that has achieved anything like UHC has done it through the public assurance of primary healthcare....to strengthen public health service delivery, large proportion of the additional expenditure should be ring-fenced for primary healthcare, primary

health centres and community health centres.' What has transpired, in contrast, are 'unkind' cuts in allocations for nutrition schemes and those meant for maternal care. Mohanty (2021) writes about the 'unkindest cut to hit children' in this crisis time and states, 'For 2021-22, the [central] government has earmarked only Rs.21,105 crore for this scheme [for the ICDS and school meals], while clubbing it with additional schemes. Last financial year's combined budget allocations for all these schemes (*Poshan Abhiyan*, the national nutritional mission) was Rs 24,557 crore, 22 percent higher than this year's allocation.'

Again, this year the *Matribandana Yojana* – a financial assurance programme for every woman after the birth of the first child – has been clubbed with two other schemes and is now called *Samarthya*. However, the same amount is allocated for *Matribandana* and *Samarthya* (Khera 2021), suggesting an attempt to run two schemes with one financial pot and thereby effectively hitting each with a budget cut. The crisis time thus appears to encounter roll back, and not roll out, of some of the key centrally sponsored schemes that have been designed to protect the health of the mother and the child. It is against this backdrop that our findings from the state of West Bengal on the resilience or otherwise of some of these basic health services have been presented later in this report.

Public Distribution System (PDS) in 'Normal' and 'Crisis' Times

Many have lost their jobs during the pandemic, no matter how irregular, informal or casual they were; many have not earned any income during the national lockdown,' many jobless migrant workers have undertaken perilous journeys back home in pitiable conditions. The acute 'financial stress' that many people have experienced as a result of such overlapping layers of distress has compelled them to consume less food. But as Dreze (2020) perceptively observes, '...the PDS is preventing the worst....an overwhelming majority of poor households are currently receiving food rations.' Although PDS cannot ensure adequate protection against nutritional insecurity that millions of Indians routinely face and the nutritional losses that they have suffered especially during the Corona virus pandemic, its role to offer a minimum protection against hunger is unmistakable. Disruptions, if any, in the functioning of the PDS during the

lockdown and post-lockdown months in West Bengal are, therefore, a focal aspect of our present enquiry.

This is especially so in the light of looming food insecurity that the underprivileged sections of our country are evidently experiencing now, as many recent studies vividly demonstrate. In particular, a study conducted by The Rapid Rural Community Response – a collective of over 60 NGOs – has collected data in three rounds since the announcement of the national lockdown. The latest round has covered the period between December 2020 and January 2021, collecting data from 1176 households in 64 districts in the states of Assam, Bihar, Chattishgarh, Gujarat, Jharkhand, Madhya Pradesh, Maharashtra, Rajasthan, Telengana and Uttar Pradesh. As Singhal, Rajendra and Sarin (2021) cite from this study, '....the most recent data suggest a persistence of cutting down on food even nine months after the first lockdown during the seeming “revival” period. While 40 percent of the sample cut down on food during the first lockdown, an alarming 25 percent reportedly continued to cut down on food during the most recent survey conducted in December 2020-January 2021....Households reported cutting down on nutritious food – 80% cut down on milk, vegetables, pulses and oil (around 50% reported cutting down on pulses alone)....the poorer, socially marginalized Dalits and those with lesser access to food security schemes such as migrants faced more severe food scarcity....Around 30 percent of households were also seeking loans, and among them, at least half of them reported needing loans for food, all indicative of the debilitating food and financial insecurities that poor households continue to face.'

The persistence of losses in food intakes in many households throughout the pandemic, coupled with financial losses caused by their compulsions to take loans for food, justifies the insistence on demanding uninterrupted and even augmented PDS services in all weathers. In the following pages of this report the PDS in West Bengal has been studied from this standpoint.

The 'Jobless' Growth of the Pandemic and the NREGS

Sudden but widespread unemployment post the national lockdown has let the already precarious status of casual workers, home based workers, weavers, artisans,

street vendors, construction workers, riskshaw pullers, domestic workers and sex workers slip into deeper predicament. Poverty of lives and of livelihoods has co-mingled to produce acute destitution and desperation among large sections of the population. The urban workers have been hit particularly hard by the impact of the COVID-19 pandemic, as Bhalotia, Dhingra and Condivolli (2020) clearly show. Counting together those who were unemployed or reported zero hours of work during May-July 2020 and those who had already been out of work since the beginning of the lockdown and had received zero pay in April, 2020, the authors suggest that as high as 52 percent of urban workers went without work or pay during the lockdown. Their joblessness also entailed, quite unsurprisingly, huge losses in their incomes, falling on an average by 48 percent post the lockdown in April-May 2020, compared to labour income in January-February 2020. The National Rural Employment Guarantee Scheme (NREGS), the largest employment programme in the world guaranteeing 100 days of work to households is confined to rural areas only. Many scholars are forcefully arguing in favour of an explosion of NREGS work as well as its expansion in urban areas in the face of a severe crisis of work all across the country in this pandemic season (Dreze 2020).

A recent study suggests (PAEG 2020) that due to the return of migrants and the stagnation in the rural economy there has been an increase in demand for NREGS employment in rural areas as well, and that new households are registering for job cards and work. Disconcertingly, however, there is a significant difference between demand for and actual provision of employment, with 22 percent of officially registered demand having remained unmet for the country as a whole. To put it differently, according to the findings of this study, '....1.7 crore people who have demanded work have not been provided employment.'

In response to the pandemic, this year (2020-2021) there has been an increase of one lakh crore in the NREGS allocation. This is, however, lower than what the situation demands (ibid). The allocation is 0.47 percent of the GDP. In an earlier estimate of fund requirements, Murugai and Ravallion (2005) suggested that 1.7 percent of the GDP needs to be allocated for the NREGS for its robust functioning. Also, the allocated funds need to flow uninterruptedly and in a

timely manner in order to avoid drying up of the fund that has occurred in the last few years causing huge arrears in wages (Dreze 2020).

According to the PAEG report (2020), the percentage of people who demanded but did not receive employment in the reference year in West Bengal was 21.4. The present enquiry attempts to examine how the NREGS in the state has responded to the demands of work that households have made during the COVID-19 pandemic.

Community Health Workers as the Grassroots Architects of COVID Management

If this report has paid any attention, albeit modest, to the examination of responses of the medical set up and the medical fraternity to handle the pandemic situation, it has done so through the standpoint of frontline health workers. Undoubtedly, doctors, nurses, health department officials, ambulance workers, waste disposal staff, workers at crematoriums, corporation staff, workers in medicine plants and diagnostic laboratories and the local police- all have made critical contributions in either monitoring and/or mitigating the transmission of the COVID-19 contagion (Bhaduri 2020a, Sarkar 2020). This report admittedly remains limited because of its near-exclusive focus on Accredited Social Health Activist (ASHA) workers, with occasional glances cast at the contributions of Auxiliary Nurse Midwives (ANMs) and Anganwadi Workers (AWWs), to the relative neglect of the role of other health care professionals and workers whom we list above. Yet this in-exhaustive account gives us an opportunity to shed light on the critical role that this routinely under-valued cadre of workers have performed to handle the pandemic-triggered challenges, playing an integral part in disease surveillance and mitigation (see BEHANBOX 2021).

Their reach and influence within the community have proved to be their professional riches at this crisis hour. They have taken active part in field surveillance activities, including visits of quarantined people at home or in treatment in isolation centres. Putting aside personal safety concerns, family pulls and pressures, social harassment, departmental neglect and above all challenges of field visits in the absence of decent transport facilities, these community workers

have run the local engine of healthcare with care and sophistication so much so that '....they have become de-facto public health employees' (Bhaduri 2020b). They seem to have transcended their role as mere community outreach workers to provide camaraderie and partnership to the medical workforce. That they have been active agents in containment and mitigation efforts against the Corona virus has been carefully documented in many recent studies and commentaries.

The long list of activities performed during the pandemic by the ASHA staff includes, among others, Corona tests for several crores of people, submission of daily reports of the health status of quarantined people, communication of health safety measures to the local public, coordination with Panchayat members, house visits, monitoring of migrant workers, checking temperature of the people with thermal guns at district borders, arrangement of ambulances to transport Corona patients and so on (Bhattacharya 2021). Their workload has increased manifold, but their take-home income has fallen, since their 'performance incentives' for institutional deliveries, child immunization and health check-ups for pregnant women have dried up due to a decline or stoppage in these services during the pandemic. And yet, in their words, 'People appreciate our work; when we visit them at their home, they offer us a chair to sit on'. This grassroots partnership during the pandemic between ordinary people and frontline health workers is worth probing, as we attempt to do in this report, in order to get an idea about how the 'frontline victims' and the 'frontline health workers' collaborate to cope with this social predicament.

Public Response and Responsibility as a 'Social Vaccine'

While COVID-19 infection control and overall management of this bio-medical crisis, including the vaccination policy, and related dimensions of its production, pricing and distribution, are not at the heart of the present enquiry, an important element of this study swirls around people's awareness of the risks of COVID-19 transmission, their understanding of affordable yet effective basic prevention measures such as correct and consistent mask wearing and their sense and sensibility about the need for their own behavioural changes. This is because public access to COVID-19 information, their attitudes and behavioural practices

give us an idea about whether people have been empowered with the critical information about the disease contagion that often remains confined within the domain of experts. Similarly, whether their agency as citizens guides them in the direction of responsible public action is a matter of interest. As Kumar (2021) perceptively observes, 'Relying solely on medical science, especially treatment, takes the agency away from the average people to act.' Citing a global survey of COVID-19 knowledge, attitudes and practices (KAP), conducted by the Johns Hopkins Centre for Communication Programme, the author informs us, '...from July 2020 to March 2021, India saw a 5% drop in mask wearing.' What is essential, therefore, as she helpfully argues, is to ascertain '...whether people have the basic information why mask wearing can effectively prevent COVID-19 transmission, and on when, where, how and what types of masks one should wear to protect an individual, a family, and a society from the transmission of this deadly virus'.

People's awareness, activism, and action, thus, lie at the heart of a society's pandemic response. Indeed, people's understanding and behavioural modifications are deemed as a 'social vaccine' by public health experts, which is as important as a bio-medical vaccine (Tharyan and John 2020; John and Seshadri 2020; Bhaduri 2020b). To quote Tharyan and John (2020), a social vaccine '...is a metaphor for a series of social and behavioural measures that governments can use to raise public consciousness about unhealthy situations through social mobilisation.' Recounting strategies that effectively brought down the incidence of HIV infection during the HIV/AIDS pandemic, John and Seshadri (2020) assert that this social vaccine includes public education and social mobilization. Inspired by this line of thinking, the present study attempts to gain an inkling, albeit through a less-than-ideal remote telephone survey, of people's knowledge, attitudes and practices vis-a-vis measures that can contain this contagion.

Precarity, Invisibility and the Pandemic: A Chronicle of Migrant Workers

This report focuses on the experiences of migrant workers from West Bengal who returned home during the lockdown and post-lockdown months, followed in some cases by a journey back to their earlier destinations after a little while. While

we keep in mind that migration has its own promises, and not just associated perils – the well-heeled 'digital nomads' who for instance work in the IT sector are a case in point – we seek to chronicle here, to the best of our abilities, the challenges that the mostly invisible, precarious, semi-skilled and unskilled informal migrant workers from West Bengal have faced during the pandemic. By the sheer logic of labour market calculus and livelihood opportunities, to work as migrant workers in distant lands is surely their choice. But they choose under severe constraints that are rendered more acute due to the absence of decent conditions of work, housing, and social protection, and on account of the disconcerting worker-unfriendly dilutions of labour laws in recent months in a few Indian states (Roychowdhury 2020). Their freedom of choice, at times, ironically looks like a freedom 'to lose'.

Several media reports and scholarly studies have compellingly placed before our own eyes the hardship and misery that this 'invisibilized' workforce has gone through during the pandemic (Sainath 2020, Sampath 2020, Mander 2020, MCRG 2020, among others), in the face of either poorly coordinated or non-existent governmental measures that ideally required a centrally planned and executed network of supervision and assistance to facilitate ease of movement of stranded migrant workers across states, that sealed their borders to implement the lockdown. That *Shramik* trains were run by the Indian Railways to carry migrant workers from different parts of the country, and that road transport was also organized for their movement later on, as indicated in the National Disaster Management Authority Report of 2020, are 'post-responses' to an avoidable fire of distress that the workers had to fight almost singlehandedly. Encouragingly, the present report suggests that a number of civic bodies and, on a few occasions, sections of public officials have extended support to them in varying degrees during their arduous journey.

Before delving into the details of what our exploration reveals in the following pages of this report, we recount what is now a truism, namely, that there is a huge lack of data on migrant workers, described as a 'black hole' (Mohanty, 2021a), peopled with migrant workers who are a 'ghost among citizens' (Sampath, 2020). As per the dated Census 2011 data, India's migrant workers are 5.6 crore in

number. The more recent scenario must have altered a lot. In response to a question in the Lok Sabha, the Labour Minister, citing data obtained from various state governments, stated that nearly 1.14 crore migrant workers had returned to their place of origin during the lockdown (as quoted in Mohanty 2021). Cycling or walking many miles, travelling on bus rooftops, and experiencing harassment at various checkpoints, these otherwise invisible people on their unending perilous journeys (Mander 2020) became visible to us and to the rest of the world, although still missing from official statistics. To get around this problem of data availability, we have made use of an official record of the migrant workers who have returned to three districts of West Bengal, namely, Murshidabad, Maldah and Birbhum, during the pandemic season and then randomly selected 500 respondents from this pool to conduct an elaborate telephone survey, gathering details of their destination, recent work history and nature of work, pre-lockdown and post-lockdown incomes, the vicissitudes of their journey, and their experience after return. The pre-existing sample from which we have randomly selected our respondents has surely left its own effect on our smaller sample. In addition to this 'sample effect', we also recognize that our analysis confined to three districts of West Bengal also carries the marks of 'district effects'. Acknowledging the challenges of information poverty as far as migrant workers are concerned and making no claim about our sample being representative, we present in the relevant section our main findings.

Data Limitations and Future Directions of Research

One critical issue that has remained largely unaddressed in this report and hence demands greater attention in our future research relates to the relative unavailability of credible, rigorous and authentic data on various dimensions of the COVID-19 contagion. Access to such information will greatly enhance our capacity to both understand the bio-medical as well as socio-economic and political aspects of this pandemic and formulate more appropriate remedial responses to the crisis that are both effective and fair.

'There is no data' has been a common refrain when questions have been raised, for example, about the number of migrant workers in the country, and the

proportion of them that has been forced to undertake arduous return journeys post the national lockdown. Again, data are difficult to come by on the socio-economic and demographic profiles of the people who contracted the COVID-19 disease and/or succumbed to their infections; the spatial and rural-urban spread of the contagion; the age-, gender- and class-caste-wise distribution of those who have been fully vaccinated so far and so on. What has been in short supply in particular is the information about the social determinants of this bio-medical phenomenon, including the 'inter-sections of socio-economic vulnerabilities' of the affected people (Deshpande and Ramachandran 2020). Looking at the sparsely available COVID infection and mortality data in India through the gender lens, for example, William et al (2020) argue, 'Early evidence indicates that males have higher overall burden but females have a higher relative risk of COVID-19 mortality.'

A few independent statistical exercises as well as rapid surveys have presented before us valuable information about the magnitude of the burden of this disease, which is being borne by the people, in its multiple dimensions and intensities. Of particular importance is an estimate of COVID-19 and non-COVID deaths during the pandemic season. Undercounting of deaths and data gaps in COVID-19 infections, a number of scholars assert, are likely to render India's COVID-19 data questionable, and more importantly, will have damaging consequences for mitigating the pandemic (Giridhar, Banaji, and Srinivasan 2021; Srinivasan and Radhakrishnan 2021). The number of 'excess deaths' in 2021, as compared to those in previous years, is shown to be several times higher in many Indian cities, for which data on death certificates from respective municipal corporations are available for the reference years, including, for example, in Kolkata (The Hindu Data Team 2021).

The under-registration of deaths, even in 'normal' times, in the country, coupled with the poor coverage of Medically Certified Cause of Death (MCCD) (Shewade and Parameswaran 2020) entails an already tottering statistical terrain within which the 'statistical fog' about COVID and non-COVID deaths during the pandemic thickens further, forcing people to run to crematoriums and other funeral sites to get an idea of the pandemic-linked death toll. Deaths during the

pandemic have indeed been of many categories – not only COVID-linked deaths – including, those linked to the lockdown, for example quarantine centre deaths, *Shramik* train deaths, deaths due to exhaustion, dehydration, hunger, medical complications, or accidents during migration. Following an innovative methodology to cull information from non-conventional public data bases and sources, Aman et al (2021) have recorded a total of 989 deaths until July 22, 2020 that are causally related to the lockdown.

The central motivation to gather and present authentic data pertaining to the epidemiological as well as social dimensions of the COVID-19 contagion is to empower people with information, over and above guiding the administration and the community of experts, to examine the challenges at hand and act upon them. Lack of open access to credible statistics goes against the grain of people's democratic right to information, and hence is disempowering. Also, data systems need to create space for the participation, involvement and intervention by the local people, including intervention by frontline workers. In other words, data systems and sources need to be protected against centralization which more often than not denies public the information that is rightfully theirs. Citizens' inclusion and participation in data construction and governance is thus an objective that our future research pursuits will aim to scrutinize more fully.

The themes of this report thus introduced, we next turn to delineate our methods of enquiry and then present our findings from the state of West Bengal.

Opportunistic Methods of Enquiry

As delineated in the introductory chapter, the central questions that motivate this research swirl around some of the core health capabilities of the people that have been severely compromised during the COVID-induced perilous times; the study also seeks to look into the reach and effectiveness of governmental and public action in mitigating these social woes. We raise these questions not just because these are persistent 'normal time' problems but also because they get exacerbated during the crisis times. As a first step of this investigation, here we address the question of what is new in our methods of enquiry.

Methodological Apparatuses

Conducting this research during the trouble-torn months in the recent past has thrown up a number of methodological challenges before the team that in turn have prompted a creative search on our part for what is feasible under the circumstances, not ignoring the demands of academic rigour in the process. We surely acknowledge the limitations of the methodological apparatuses that have been used but also describe their relevance, precision and credibility. Stripped to its essence, what we attempt to describe below upholds the idea forcefully articulated by Professor Amartya Sen that dealing with the pandemic is not like a centrally-led, individuated war, but is rather contingent upon a collective and cooperative choice and strategy. To put it in our context, our choice of investigative techniques has turned out to be a collectively designed collaborative endeavour.

Why Not 'Methodological Opportunism'?

Political theorists Przeworski and Salomon (1988) have encouraged researchers to be methodological opportunists and choose whatever methods of enquiry appear functional and within reach, ensuring at once their validity. At a COVID-19 and

lockdown-constrained time when standard methodological tools such as face-to-face field survey, ethnographic enquiries or case study methods have been rendered unavailable or unpredictable, the team has considered it fit to follow the instinct of opportunism in its choice of investigative strategies and has drawn on multiple methods, including, telephone surveys, online focus group meetings, videography of people's narratives, and limited field visits and face-to-face interactions wherever possible.

Despite the several limitations in telephonic survey, we have tried to keep the following factors in mind: geographical, gender and social group distribution of the samples. For example, please refer to Table 2.1 and Table 2.2, respectively, for geographical distribution of the sample on “COVID Awareness” and the one on the Public Distribution System (PDS) and the National Rural Employment Guarantee Act (NREGA).

Putting Together a People's Telephone Directory

To organize a large-scale telephone survey to cover around 2000 households and converse with approximately 500 migrant workers and 150-200 frontline healthcare workers requires at the outset a large database of telephone numbers of prospective respondents, much larger than the intended sample considering the likelihood of inaccurate numbers, unreachable numbers, and of the reluctance of some individuals to respond when contacted. Ideally, this list of contact numbers must also have a regional/inter-district spread, across rural and urban locations, such that the unfeasibility of random sampling under the present circumstances is partially compensated for. Without having access to official or company-controlled telephone/mobile data bases, generating a people's telephone directory has proven to be one of the first-order challenges for the research team as well as one of the prime reasons to draw on available social resource and support base.

Reaching out to migrant workers has its particular complexities, as it is supposed to be a purposive sample by design, selecting only those households that have at least one member who has migrated elsewhere for work. Pratichi's earlier research-cum-action collaborations with local officials, panchayat members, and various civil society organizations have come out as a major resource in identifying

migrant workers, accessing their contact numbers, and in gathering some essential details about their return journey home from their place of work during the lockdown period. Analysing these details as well as interpreting the information collected through the interview schedule that the team has designed to probe their experience further are likely to shed much light on the unprecedented movement of people that the country has witnessed during the lockdown.

Snowball Effect of Social Connection in a Climate of 'Social Distancing'

The snowballing method of reaching out to the reference population is a standard method used in normal times. However, during these perilous times this method has acquired a special meaning in that it has not only magnified the sample like a growing snowball, it has also amplified the value of social connection, especially at a time when 'social distancing' has been routinely advocated as a survival strategy. It would have been very difficult for the research team to carry out this study without the crucial help of the 'Friends of Pratichi' – schoolteachers, grassroots healthcare workers, local officials, panchayat members, local journalists and others who have regularly participated in the Pratichi Annual Workshops held at Santiniketan for the past several years and have become Pratichi's research collaborators in the true sense of the term. They have greatly facilitated the team's on-going investigation. Quite often the team has requested one facilitator to get for them two or three additional contact numbers and other relevant details, keeping in mind that they too are strapped during this time. This has generated a flow of contacts and information, admittedly interrupted at times due to unforeseen challenges but never completely halted.

Disconnect: Private Hardship and Public Deficiency

Connecting with the respondents has thrown up additional challenges but in the process it has also provided a window through which the team has observed the new social realities that have been unfolding during the crisis. Quite a few contact numbers that the team has tried to access have no incoming call facilities or are unreachable numbers. So these are numbers that formally exist but are practically non-existent for social contact, hinting at the enormous socio-economic

hardships that their owners are going through in recent times. This demonstrates the limits of a telephone survey as well. Importantly, though unsurprisingly, such instances of private hardship seem to have a class or community character, as some team members have observed. For example, quite a few contact numbers in a particular locality peopled mostly with the weaving community have been found to be unreachable, suggesting that many of them have perhaps lost their means of livelihood. Instances of 'disconnect' also seem to have a spatial character in that there are inter-regional variations in this respect. This is suggestive of the lack of connectivity and network problems which in turn reveal public deficiencies in ensuring digital access to all. In addition, a massive super cyclone with sustained winds of nearly 133 km per hour, battering the essential services including mobile connectivity posed a challenge to our telephonic survey. Similarly, some respondents have been lost due to poor phone connections, or because they did not pick up the phone after the first call.

Once all this is counted and respondents are reached out, interviews may still get, and indeed have got, stopped half way through due to the reluctance of the interviewee to continue the conversation. In some cases, our team members surmise, the 'what is in it for me' syndrome has taken effect, making it that much difficult for us to locate respondents who are willing to share information with a research team that cannot promise to deliver any direct benefits.

When Is a Good Time to Call?

The usual difficulty of finding a time that is convenient for the respondent gets further accentuated during this crisis period, as the team has realized. Even people without work are busy looking for any opportunity that may arise for eking out a living. So their 'forced' leisure is also a busy time, making them unavailable for a telephone conversation. Usually those who are willing to speak prefer the evenings; however evenings are also meant for local *addas* in a neighbourhood teashop thronged usually by men, who carry their mobile phones with them. Some female respondents are, however, available for an interview in the afternoon once they get some respite from their household duties. Our methodological foray into the intra-family distribution of opportunities and resources is also revealing.

Information Asymmetry within the Household

Our method of enquiry has further hinted at a kind of information asymmetry within the household and its gendered nature. Women 'roll *rotis* at home' in the evening, and not unexpectedly have a disproportionate share of household duties including those related to procurement and preparation of food. They are the ones, therefore, who are more informed, as compared to their spouses, about the workings of the 'ration' shops and their household entitlements. The research team, therefore, has made special efforts to talk to women while gathering information on the functioning of the public distribution system during and after the lockdown period. However, telephone conversation with them has remained a challenge for the team; this is because there is an inherent gender bias in telephonic surveys. As scholars such as Agarwal (2021) and Alvi et al. (2020) point out, women respondents often lack personal mobile phones or privacy.

From Distrust to Trust: Closing the Communication Gap

All the limitations of a telephone survey acknowledged, one may still experience, as the team has indeed done on several occasions, a dynamic evolution of long-distance communication from an initial phase of scepticism and hesitation bordering on distrust to a stage of growing trust and willingness to speak and share experiences of difficulties and struggles with others. The team has given particular attention to the criticality of the art of communication that may bridge the gap that may exist between the persons at the two ends of the telephone line. In one instance a conversation in the evening ended on an unfriendly note. With some help from a local Inspector of Schools, on the following morning the team resumed its conversation with the same respondent – a schoolteacher in a tribal area – who not only cooperated fully in completing the interview but greatly facilitated a few other interviews in the locality by lending his phone to those 'mobile-less' families. That a methodological probe demands repeated trials and errors in the interest of reducing the margin of error is the lesson that the team has drawn from this exercise. Furthermore, that an investigation is not just a technical affair but a social endeavour requiring collaboration and camaraderie is the sentiment that inspires this research.

Methodology as a Self-reflexive Learning Process

These are excerpts from the 'field diary' of a member of the research team:

“The three phases of the study were also a learning experience for me, where the insights gained from each round of the survey fed into my way of conducting the interviews in the next round.....I found that most of the male respondents preferred to be interviewed in the late evening when they would be back from work or pre-dinner *addas*. Female respondents were comfortable being interviewed in the afternoon when they had some respite from the household chores. The introduction to the respondent and making them comfortable to answer questions were crucial.

....In several cases, respondents who were initially wary of sharing information did open up when it was explained to them that the information was to be used for the purpose of a research report, and by a Non-Government Organisation (NGO) associated with Prof. Amartya Sen.

...The second phase of the survey – the Mother and the Child survey – posed one of the greatest challenges. ...However, there were also cases where the respondents were eager to share their experiences once the name of the Accredited Social Health Activist (ASHA) worker in their region was mentioned. This indicated a good rapport of the ASHA workers with the respondents.

....It was also quite a challenge to get information from the ASHA workers themselves. Several of the ASHA workers were apprehensive of sharing their records on expecting or lactating mothers. In spite of persistent follow-up on my part, many of them either stopped receiving my phone calls, made excuses, or directly told me that their superior functionaries in the health department had cautioned them against sharing the information required by us, which they considered confidential.

....My personal experience in using this method of telephonic interview has taught me one important thing – the importance of listening. The COVID and the lockdown situation has imposed a massive physical, psychological and financial burden on the people, especially on those belonging to low income groups. Despite the support – public or private – they have received, it is a huge

struggle for them to maintain their families in these circumstances. In many cases, respondents enquired whether the information they provided to me would lead to any financial support for their households. I had to inform them that there was no such financial support linked to the survey. However, I also found that interacting with them with sensitivity and empathy provided some emotional support to them. Several of the respondents told me that they felt their burden lightened because someone had listened to them and asked them about their problems. While acknowledging the value of structured questionnaires, I consider it an important part of any methodology to not work against time in getting answers, and to let respondents talk and share their problems for the purpose of a study in such a grave social situation having a massive impact on households.”

Crisis Begets Innovation: Data Collection Using Tab and Mobile

The data has been collected using an open-source platform called Kobotoolbox, supported by leading UN agencies including UNICEF, UNDP, UNHCR and the World Bank. The technical team of Pratiche led by its National Research Coordinator oriented the team on the use of the tool through a day long workshop. This has enabled the capacity of the team to collect the data efficiently during telephonic survey. The tool saves time and we could avoid some of the extremely time consuming steps of data entry as the data is sorted directly in useable format, for example, excel or csv. A flow-chart is given to illustrate the online data collection process.

Flow chart on how data was collected using kobotoolbox

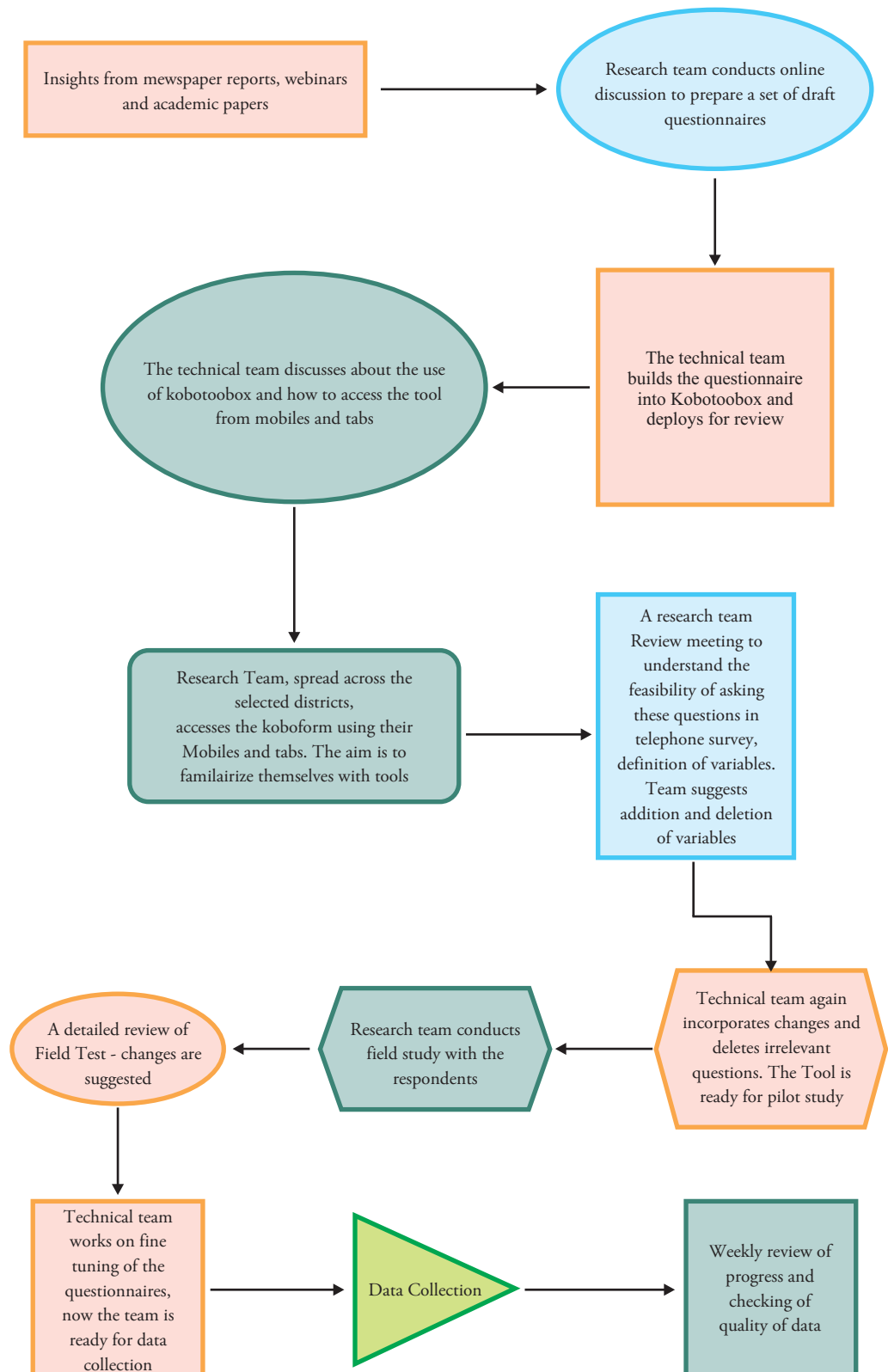


Table 2.1: District-wise distribution of sample for the 'COVID awareness'survey

Characteristic	N=500 ¹
Alipurduar	33 (6.6%)
Bankura	32 (6.4%)
Birbhum	60 (12%)
Cooch Bihar	17 (3.4%)
Dakhin Dinajpur	30 (6.0%)
Darjeeling	5 (1.0%)
Jalpaiguri	10 (2.0%)
Kolkata	85 (17%)
Murshidabad	54 (11%)
Nadia	60 (12%)
North 24 Paraganas	66 (13%)
Purulia	28 (5.6%)
Uttar Dinajpur	20 (4.0%)

¹ Statistics presented : n (%)

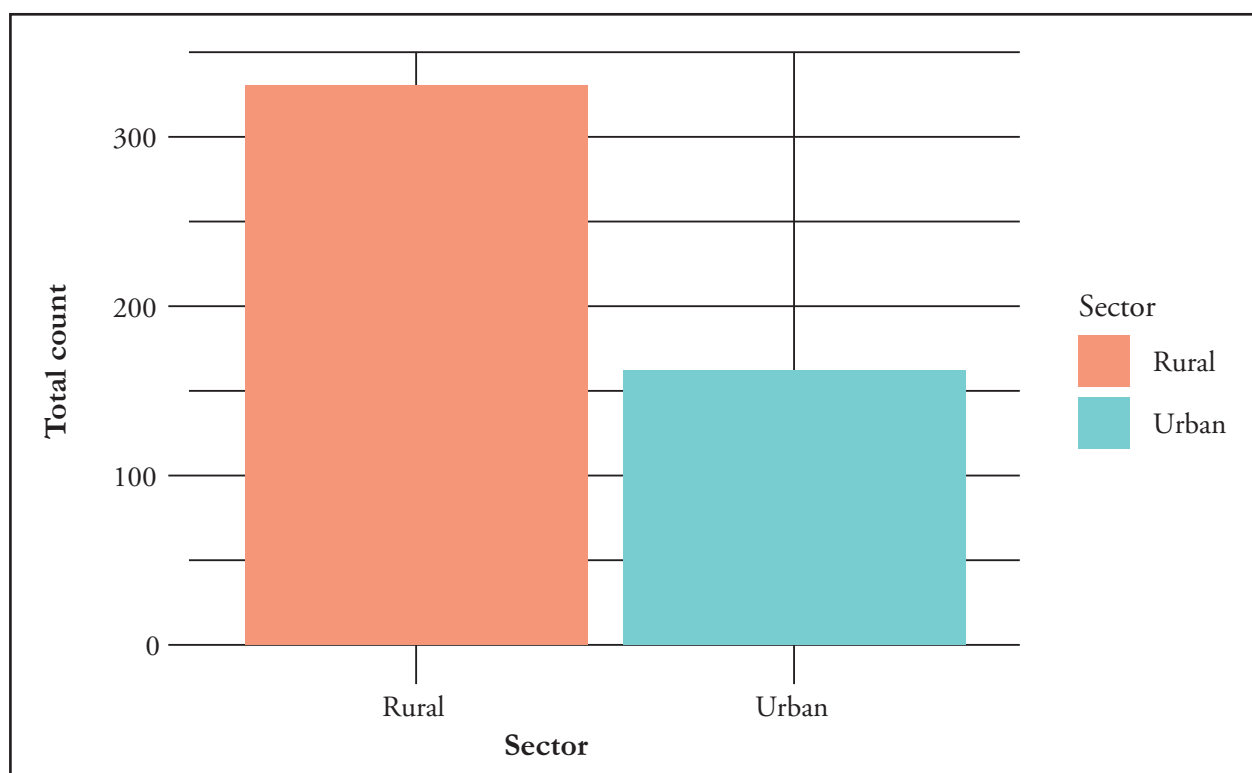
Figure 2.1: Rural-urban distribution of sample for the 'COVID awareness'survey

Table 2.2: District-wise distribution of sample for the PDS and NREGA survey

Characteristic	N=500 ¹
Bankura	40 (8.0%)
Birbhum	60 (12%)
Cooch Bihar	40 (8.0%)
Dakhin Dinajpur	40 (8.0%)
Kolkata	60 (12%)
Murshidabad	40 (8.0%)
Nadia	40 (8.0%)
North 24 Paraganas	60 (12%)
Purba Bardhaman	40 (8.0%)
Purulia	40 (8.0%)
Uttar Dinajpur	40 (8.0%)

¹ Statistics presented : n (%)

Focus Group Meeting: On-line

Accredited Social Health Activists (ASHAs) and Auxiliary Nurse Midwives (ANMs) are a critical focal group for the purpose of our research, as these frontline health workers appear to have both shouldered the main brunt of the delivery of whatever services the official healthcare system has managed to offer to deal with the enormity of the COVID crisis as well as faced huge personal health-related and other social risks in doing so. At a time when the standard method of utilizing face-to-face focus group meetings as a source of information and insights has proven highly problematic, the Pratichi team has gone on-line in organizing a virtual focus group meeting involving around 30 grassroots healthcare staff working at different districts of West Bengal. The team has gained enormously in terms of learning from their experience and refining its questionnaire to conduct a larger survey on them, through their participation and highly valuable inputs at this meeting. It also seemed as though the virtual focus group discussion was more candid compared to the actual ones in the field. The participants opened up with greater candour as they didn't feel intimidated by the physical presence of persons higher up in the rung, politically, socially or administratively.

Gathering their contact numbers, and persuading them to participate at this focus

group assembly taking time off from their extremely busy schedule have proven to be a rewarding as well as challenging methodological exercise.

Limited Field Visits as a Precious Tool

Severe restrictions on movement during and even after the lockdown period notwithstanding, a few members of the team have made a special effort to visit the 'field' wherever and whenever possible. This act of stretching of methodological opportunism to a considerable extent has required quite a bit of planning and organization on their part as well as personal risk-taking. Videography of some of these trips has been attempted in order to record the first-person account of people's woes as well as their relentless efforts to not only take care of their own families but to try to make a difference to other people's lives. We place below an image, collected from such trips, of migrant workers who seem to have seized whatever occupational openings they have got under these circumstances to eke out a living after their return.



Rural distress: Migrant workers selling vegetables



Oral inoculation of a child during the pandemic

Mother Care, Child Care: Disrupted by COVID Care?

When the entire world was finding itself unprepared against the sudden attack of Severe Acute Respiratory Syndrome Corona Virus - 2 (SARS-CoV-2), commonly known as COVID-19, two ladies, Jacinda Ardern, Prime Minister of New Zealand and K. K. Shailaja, former Health Minister of Kerala, rose to fame for their prompt and appropriate actions to control the situation in their respective states. Though they were highly successful in their endeavour, both of them were sure that whatever they have done is not going to be sufficient to end the pandemic in short run and therefore, continuously upgraded the facilities, services and the policies, keeping an open mind for latest information, suggestions and criticisms.

Not only the women in high echelons of power, women in general were on the forefront in the fight against COVID-19 pandemic worldwide as they globally outnumbered their male counterparts in the field of health and social care workforce. At the global level, women health workers are observed to be two to three times more at risk than their male counterparts (Azcona et al). In India, the role played by nurses, Accredited Social Health Activist (ASHA), Auxiliary Nurse Midwife (ANM) and Anganwadi workers is acclaimed widely. Despite their commendable role in the fight against the pandemic, women worldwide in general and particularly in India suffered a great deal in almost all aspects of daily life; and the children suffered along with them.

This section of the study looks into the trials and tribulations faced by pregnant women and new mothers, whose children were born just before or during the first lockdown period (2020). We also aimed to understand the situation of families with young children. As part of this, we also look at the functioning of the government's food and health support programs for women and children during the pandemic.

The study interviewed 474 households over 17 districts of West Bengal. Due to the nature of the survey, which was telephonic and based on information given by

health functionaries, it was not possible to maintain uniformity of the sample across districts.

Table 3.1: Distribution of sample households across districts of West Bengal

District	No. of households interviewed	District	No. of households interviewed
South 24 Paraganas	13	Hooghly	45
Purba Bardhaman	15	Cooch Behar	48
Jhargram	16	Dakhin Dinajpur	50
Jalpaiguri	19	North 24 Paraganas	55
Nadia	25	Murshidabad	57
Bankura	26	Birbhum	61
Purulia	38	Other districts ¹	7
Total			474

Profile of the Sample

Social profile

Of the 474 respondents, the majority could be classified as General Category. Almost half (231 i.e. 49%) of the respondents were from the general category. Another 22 percent were Scheduled Caste (SC) respondents and 16 percent belonged to the Scheduled Tribe (ST) category. About 11 percent belonged to the Other Backward Communities (OBC) category. These categories were also unevenly distributed among the districts; for example, a majority of the respondents from Purulia belonged to SC communities, much higher than their representation in other districts. Among other districts, there were a sizable proportion of SC respondents in Cooch Behar, Nadia and Birbhum. The highest representation of STs was in Bankura followed by Purulia.

In terms of distribution of respondents by religion, we found that the majority of respondents (69%) were Hindus. Among the minorities, the largest one was Islam (27% of respondents were Muslim). There were also 4.2 percent respondents who followed other faiths, and just one respondent (0.2% of the sample) was a Christian. Distribution by religion was also uneven among districts. Respondents in Hooghly, South 24 Parganas, Jhargram, Purba Bardhaman were entirely

¹ We could interview only 1 respondent from Howrah, Kolkata, Uttar Dinajpur and 4 from Alipurduar, since the numbers were very low, we clubbed them together.

Hindu. Among other districts, Muslim respondents were mainly concentrated in Murshidabad, North 24 Parganas and Cooch Behar and Dakshin Dinajpur. In Bankura 11 respondents said they followed other religions.

Since most of the respondents were parents of young children, the age distribution was also heavily tilted in favour of respondents below 30 years of age. Respondents in this age bracket form 63 percent of all respondents across the state.

Economic profile

The overwhelming proportion of respondents has ownership of their house, so we have not used home ownership as an economic indicator. The economic level of the respondent households may be estimated by several indicators such as the source of drinking water, availability of latrine, and the major source of household income. We find that there is not much difference between the proportion of respondents drawing drinking water from public (45%) and private (50%) sources over the state, but the differences are marked among districts, for example, most of the respondents in Bankura and Purulia draw drinking water from public sources. On the other hand, a large section of the respondent households in South 24 Parganas, Dakshin Dinajpur and Cooch Behar, have private sources of drinking water. Similarly, Purulia is the one district where almost all respondent households use public sources of water for other purposes than drinking; Birbhum and Purba Medinipur are the two other districts where more than half the respondent households depend on public sources of water. Respondent households in most other districts largely have their own private source of water for other purposes.

A reasonable proportion of the respondents are salaried (12%), while another 14 percent is self-employed, and 5 percent are professionals. Apart from these three categories, totaling 31 percent of the respondents, other categories are artisans, non-agricultural wage earners, agricultural labourers, sharecroppers, cultivators, and regular wage earners. The single largest proportion among the respondents consists of cultivators, forming 22 percent of all respondents. Another 11 percent of the respondents are agricultural labourers, though there are hardly any

sharecroppers. Regional distribution of these categories is highly uneven. Birbhum, Cooch Behar and Dakshin Dinajpur have a relatively prominent presence of independent professionals among the respondents. Bankura and Jhargram have the highest proportion of salaried employees among the respondents.² Of the 75 non-agricultural wage workers in the sample, the concentration is in Jhargram, Murshidabad and Birbhum.

Another indicator of the economic standard could be the distribution of different categories of ration cards among the respondents. Priority Household (PHH) and Priority Household with Sugar (SPHH) cards are given to economically stressed or poor households, while Antyodaya cards are allotted to destitute households. There had been some reports of misallocation and leakage in the state, as it is common in other parts of the country too; households not in need of subsidized food grain are at times allotted these cards while many truly poor households are left out. Even then, the distribution of ration cards may be an indicator of economic standard. For example, our sample has 29 percent respondents with PHH and 16 percent with SPHH cards. There are also 12 households who have been allotted Antyodaya cards. Another 5.5 percent households have applied but have still not received their ration card.

From the above analysis of the distribution of social categories (caste and religion) and economic categories (occupations), we find that in our sample some of the districts have a greater concentration of vulnerable households among the respondents. Some of the districts have a large proportion of respondents from vulnerable communities, sometimes two or more vulnerable communities, from the caste and/ or religious perspective, and often these respondents are also engaged in low-paying and insecure occupations. The Table 3.2 gives a picture of the distribution of socio-economic vulnerabilities among the respondent households in various districts.

²Since Kolkata and Howrah have only one respondent each, they have not been considered here.

Table 3.2: Profile of vulnerability among sample households across districts

District	Representation of socially vulnerable communities among sample respondents	Representation of economically vulnerable occupations among sample respondents
Bankura		5 out of 26 respondents agricultural casual labour
Birbhum	20 SC; 20 ST out of 61	36 non-agricultural + regular wage labour out of 61
Cooch Behar	18 SC; 19 Muslims out of 48	
Dakshin Dinajpur	20 Muslims out of 50	10 agricultural casual labour out of 50
Jalpaiguri	9 ST; 6 Muslims out of 19	10 agricultural and non-agricultural casual labour out of 19
Jhargram	8 OBC out of 16	7 non-agricultural casual labour out of 16
Murshidabad	39 Muslims out of 57	18 non-agricultural casual labour out of 57
Nadia	5 OBC; 8 SC; 7 Muslims ³ out of 25	12 agricultural, non-agricultural and regular wage labour out of 25
North 24 Parganas	29 Muslims out of 55	
Purulia	8 OBC; 18 ST out of 38	10 regular wage labour out of 38
South 24 Parganas	11 SC out of 13	8 regular wage labour out of 13

Educational profile

Most respondents over all the districts have completed either upper primary or secondary schooling – these respondents form 43 percent of the entire sample. About 10 percent of the respondents are either illiterate or have completed only primary schooling. Such respondents are concentrated in Dakshin Dinajpur, Hooghly and Birbhum. In Birbhum, contrarily, quite a few respondents have received education up to higher secondary level and some of the respondents are graduates. Similarly, a sizable section of the respondents in Jhargram are educated up to upper primary level and up to secondary level.

Role and Functioning of the Healthcare System in the Reproductive, Maternal, and New-born Child Health (RMNCH) Sector

Within the purview of the functioning of the healthcare system, we will focus here on problems faced during institutional delivery, the role of local healthcare

³Not mutually exclusive since many of the Muslim respondents are also OBC.

functionaries such as ASHA and Anganwadi Worker (AWW) for pregnant and lactating mothers during and after lockdown, and the health support provided to the children.

As mentioned earlier, most of the respondents were the mothers of children who had been born somewhat before or during the lockdown. Of the entire sample, almost 55 percent of the respondents are mothers. Another 38 percent are fathers of the child. In several cases, brothers- or sisters-in-law responded to the interview.

Proper maternal care is not only important for the mother, but also for the newborn. Maternal health care is directly related to the unfortunate incidents of maternal and child morbidity as well as in some cases mortality. The issue of Mother and Child Health (MCH) had been in discussion in the policy domain since long; it had a specific mention in the first National Health Policy in 1983 with clear aim of reducing Maternal Mortality Ratio (MMR) from around 5 to 2 and Infant Mortality Rate (IMR) from around 120 to 60 by the end of the previous millennium. Obviously, the aim was achievable only through better care of the mother and the child, including those living in the remotest places of the country, through the three-tier health system.

The requirements were multiple and varied in nature, including contraception, antenatal care (ANC), postnatal care (PNC), proper immunization of mother and the child, dietary supplements etc. These policies took shape through the National Rural Health Mission (NRHM), launched in 2005, which not only brought in the necessary changes in the health delivery system, but also established norms for the same through the Indian Public Health Standards (IPHS). Regular data collection regarding Reproductive and Child Health (RCH) was done and published, for scrutiny by the officials, researchers and the common people. To implement the gigantic initiative, huge numbers of health workers - ASHA and ANM - were appointed, with the principal focus of improving the Reproductive, Maternal, and Newborn Child Health (RMNCH) scenario. Fortunately, these initiatives did change the scenario to a good extent, though there had been some regional variation, both in terms of efforts and outcomes. West Bengal is considered to be one of the states which have taken opportunity of NRHM to a good extent to mitigate the issues of IMR, MMR and Total Fertility Rate (TFR).

Unfortunately, however, during the pandemic, focus of these health workers were shifted towards preventing the propagation of COVID, and taking care of those already infected. In a situation in which the expectant women needed more support from them, they got lesser attention than usual.

Given the additional workload on ASHA workers during the pandemic, it is understandable that their direct involvement with the expectant/lactating mothers would decline. Our field study indicated that in three-fourths of the cases, the ASHA had not visited the expectant/lactating mother during the lockdown; however, they have played a more positive role in institutional delivery. About 59 percent of the respondents received institutional support from the ASHA for delivery. Most respondents did say that the ASHA workers made telephonic enquiries during the lockdown about whether any household members have COVID symptoms, or dengue/malaria.

Post lockdown, personal visits from the ASHA increased substantially to about 86 percent, but the increase in the proportion of ASHAs providing support for institutional delivery increased only marginally to about 61 percent.

Similarly, direct visits from Anganwadi workers during the lockdown were limited. They visited the expecting/lactating mother in only 25 percent of cases; and most of the time they did not enquire about the health of the mother or other household members. In only 12 percent of the cases did respondents report that the Anganwadi worker had enquired about COVID disease in the household. Anganwadi workers were engaged with the households primarily in supplying nutritional supplements to lactating mothers.

However, there were hardly any cases where cooked food was provided even after the lockdown; the majority of the respondents (82%) stated that they had received dry ration after the lockdown, while about 5 percent respondents had received no food support at all. The respondents who reported that they had received neither cooked food nor dry ration were found in a sizeable number in Hoogly district only.

Health checkups of older children are a regular feature of the functioning of the ICDS/ Anganwadi system. While this was affected during the lockdown, the

majority (67%) of respondents still said that their children were having health checkups as usual. In 20 percent of the cases, health checkups were interrupted during the lockdown. Remarkably, the interruption is concentrated in Hooghly, North 24 Parganas and South 24 Parganas, the districts closest to Kolkata. In districts distant from the metropolis, – Birbhum, Murshidabad, Purulia – health checkups appear to have functioned by and large normally during the lockdown. Since the lockdown was a nationwide phenomenon, not concentrated in the urban metropolitan areas, this is an unusual finding, which might perhaps reflect perception-based understanding of the respondents that may not necessarily converge with the objective situation vis-à-vis the functioning of health checkups even in non-pandemic situations. A small number of respondents (4.2%) stated that that there have never been any health check ups for their children.

Contraception

While the state of perinatal services is evident from above, which we will discuss in further details shortly, the other RMNCH services have also been affected during the same period (April-June 2019 to April-June 2020). Overall, use of major contraceptive methods has declined by 17 percent during the period, as shown in Table 3.3. Interestingly however, while use of regular contraceptives has seen a huge decline during the period, use of emergency contraceptives like emergency pills and Centchroman, which is a post-coital contraceptive, has increased considerably (see Table 3.3). At the same time use of pregnancy test kits has declined by 12 percent. All these numbers indicate towards the fact that during the first wave of the pandemic there was disruption in regular visits to the health centres by women of reproductive age, which led to use of emergency contraception methods. There might have been unintended pregnancy due to contraceptive interruption which may not be established here as the data source gives a glimpse of the situation only up to June, 2020.

Table 3.3: Method of contraception used during April to June, 2019 and 2020 in West Bengal

Methods of contraception/pregnancy test	April to June 2020	April to June 2019	Change in %
Sterilisation	17,368	28,551	-39.2
IUCD Insertions done (public facilities)	91,650	1,15,755	-20.8
Combined Oral Pills distributed	16,25,691	17,07,776	-4.8
Condom pieces distributed	56,80,109	72,32,587	-21.5
Antara Programme (all 4 doses)	38,172	51,995	-26.6
Emergency pills distributed	14,356	9,630	49.1
Centchroman (weekly pills) distributed	1,61,162	46,680	245.2
All	7628508	9192974	-17.0
Pregnancy testing kits used	3,96,579	4,51,811	-12.2

Source: HMIS (No date)

Pregnancy Registration and Perinatal Care

The impact on RMNCH in the state is evident in the figures mentioned in Table 3.3. A four-year comparison clearly shows the steady progress in almost all the indicators till 2019 and sudden decline in 2020. Since the data is available only till June 2020 (at the time of completing this report) and spread of COVID took place during March 2020 onwards, comparisons are done for the quarter April to June for last four years (see Table 3.4).

A clear decline in registration of pregnancy and decline in total reported deliveries on one hand, on the other hand increase in percentage of home deliveries to total deliveries indicate that there might have been good number of pregnancies which were not even reported on time. The number of cases of home deliveries, which was declining by a steady rate of 50 percent every year, abruptly increased by 32 percent during the period compared to the previous year. ANC's were affected; therefore, immunisation of the pregnant women was also affected; similarly, distribution of the supplements like Iron and Folic Acid (IFA) tablets was affected and there was no improvement in distribution of another important nutrient in form of Calcium tablets.

Not only ANC, post-natal care was also hampered to a considerable extent.

Lower rate of institutional delivery and lower rate of immunization during the

Table 3.4: Change in RMNCH indicators during the second quarter for last four years in West Bengal

Indicators	April to June			
	2017	2018	2019	2020
Total number of pregnant women Registered for ANC	4,55,892	4,44,863	4,50,587	4,19,560
Total reported deliveries	2,97,106	2,96,346	2,83,073	2,40,342
% Institutional Deliveries to total ANC registration	62.0	64.8	61.9	56.0
% 1st Trimester registration to Total ANC Registrations	80.5	87.4	87.9	86.0
% Pregnant Woman received 4 ANC check-ups to Total ANC Registrations	62.7	70.0	67.7	54.5
% Pregnant women received TT2+ TT Booster to Total ANC Registration	84.7	87.1	85.3	66.3
% Pregnant women given 180 IFA to Total ANC Registration	71.9	82.3	75.6	72.5
Deliveries Conducted at Public Institutions	2,25,904	2,25,685	2,22,935	1,93,385
Number of Home deliveries	14,539	7,927	4,065	5,379
% Home deliveries to Total Reported Deliveries	4.9	2.7	1.4	2.2
Deliveries Conducted at Private Institutions	56,663	62,734	56,073	41,578
% Women getting 1st Post-Partum Check-up between 48 hours and 14 days to Total Reported Deliveries	90.3	85.6	83.3	77.7

Source: HMIS (No date)

period under study may have multiple reasons. A report published in the International Journal of Gynaecology and Obstetrics (Goyal *et al.* 2020) suggests the reasons behind delay in health seeking during the lockdown had been mostly related to lack of transportation (50.9%), fear to catch the infection (33.4%) and ignorance (15.5%). The other reasons of decline in institutional delivery may have link with the fact that in many cases the entire hospital is converted to COVID hospital; increased attention on COVID patients is sometimes leading to neglect of expecting mothers; in many cases hospital admission requires COVID test, which pregnant women might have found to be objectionable and tried to avoid. Companion during labour and child birth, which is a right, was widely denied during the pandemic.

Though official data related to maternal and child mortality is not available yet, however, considering the limited capacity of the health system to cope with the pandemic, reputed journals like The Lancet reported that there was an increase in the odds of stillbirth, and the risk of mothers dying during pregnancy or

childbirth (Chmielewska et al 2021).⁴ The reports also indicated that the COVID-19 impact on pregnancy outcomes was disproportionately high in poorer countries and on vulnerable section of society in richer ones. Similarly, UNICEF has made more specific estimates about how COVID-19 will affect mortality rates of mothers and children below 5 years of age. They have also estimated the possible increase in cases of stillbirth. According to their estimation, maternal deaths in India will increase by around 18 percent, death of children below 5 years of age will increase by 15 percent, and stillbirth will increase by 10 percent (SickKids and Centre for Global Child Health 2021).

In our field survey, encouragingly, which was conducted after August 2020, we did not find many signs of systemic lacunae arising from the pandemic and the lockdown. It appears that there is adequate awareness of the need to get pregnancy confirmed and to register for delivery, and that there was no interruption by public or private facilities in these services even during the lockdown. Most respondents stated that they had got the pregnancy confirmed in time and the registration was also done in time. There are very few exceptional cases of delay, and mostly due to personal reasons. There are a few cases where the expecting mother did not realize that she could be pregnant. In a few cases, the expectant mother was at her natal home or her husband was at work. There was only one case (in Karimpur-1 block in Nadia) where the health facility refused to register the pregnancy, even though the unlock phase had already started.

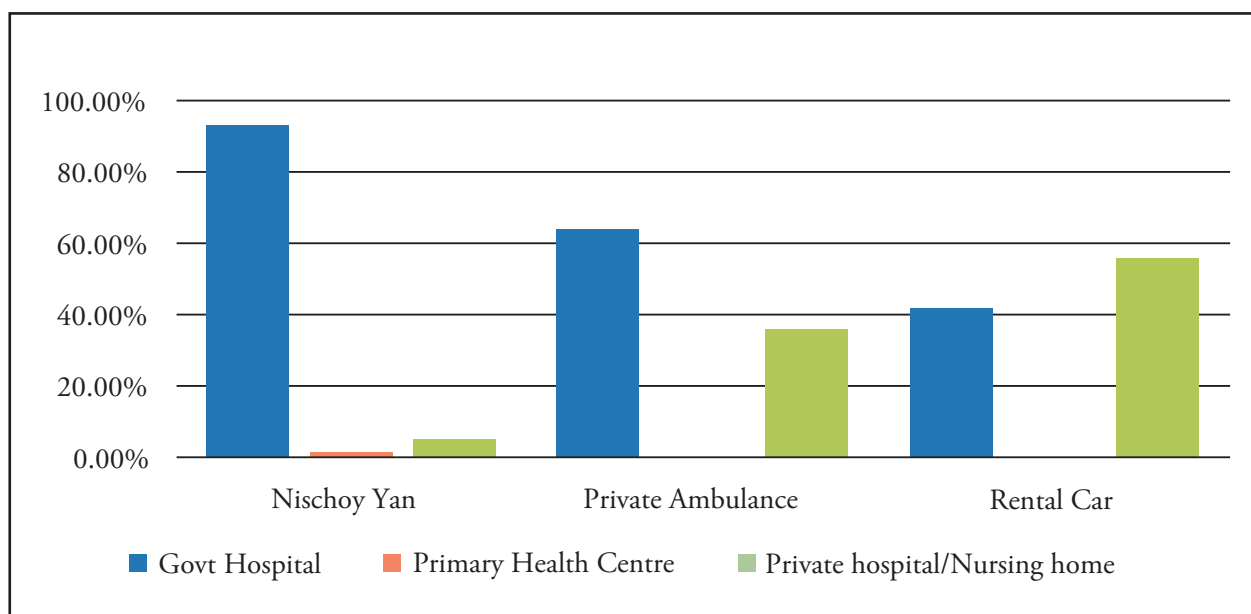
Over all the districts, the system for institutional delivery appears to have functioned fairly well during the lockdown. Of all the mothers we interviewed, we found only two cases where the child had been delivered at home, and only 3 percent of all respondents stated that they had faced refusal from government or private institutional sources for delivery. The numbers are concentrated in Murshidabad and Hooghly, but since they are small numbers, it is difficult to draw any conclusion that the delivery-related healthcare system was faltering in these districts.

In cases of delivery, we have narrated earlier that there was some decline in institutional support from ASHA workers. Transport to the health centre or other

⁴See also, The Hindu (2021)

place of delivery was one of the factors affected by the lockdown. Several of the respondents described difficulties in getting a vehicle to transport the expectant mother to the healthcare facility for delivery. The figures state that slightly more than half of the respondents used the government transportation, *Nischay Yan*, to move to the place of delivery. However, more than 30 percent also used private vehicles such as rental cars.

Figure 3.1: Health facility for delivery and means of transport used by respondents (in percent)



Source: Pratichi primary survey 2020

In case of those respondents who had their delivery in a government hospital, it is expected that the mother-to-be would be transported by *Nischoy Yan*. However, this was not the case. We found that more than 17 percent of the respondents going to government hospitals also had to use rental cars and 3 percent used private ambulances to transport the expectant mother, while 9 percent used 'other transport' (*toto* or motorcycle etc.). Looking at it from another angle, we find that 42 percent of those using rental cars are going for delivery to government hospitals. Whether this is a regular phenomenon or specific to the pandemic is not clear from the figures (since we have no comparative numbers for pre-pandemic years), but narratives by the respondents do tell a story of difficulties in government transportation and the need for making private, often barely

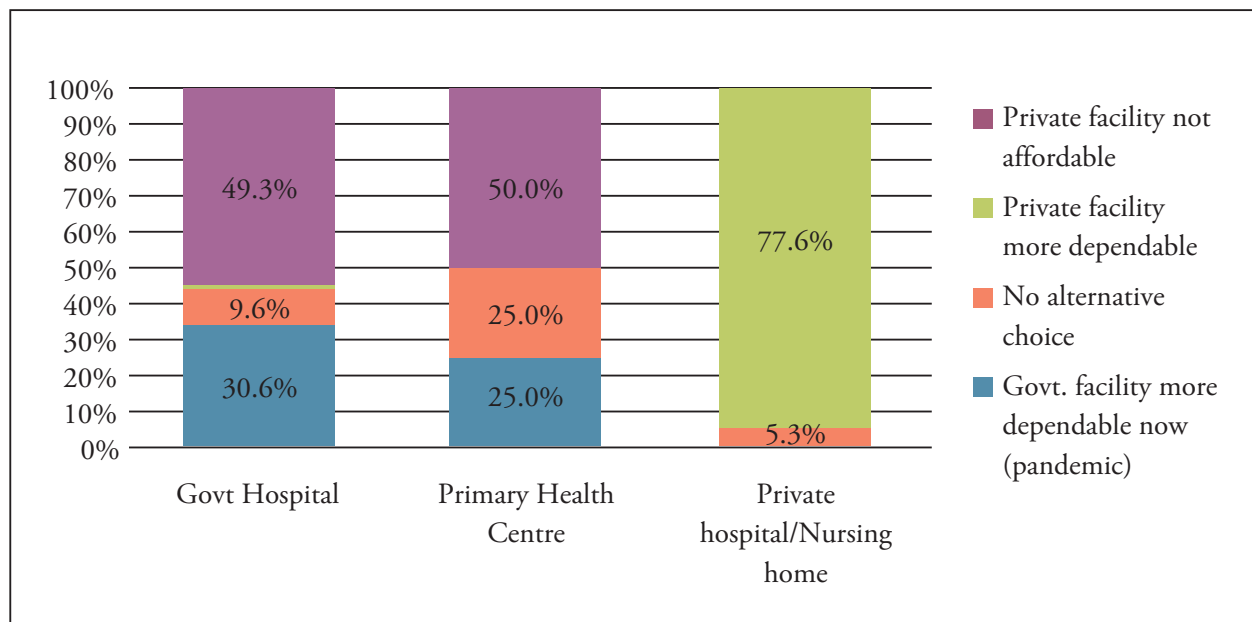
affordable, arrangements. There were several cases where the *Nischay Yan* reached late and the respondents were forced to rent a private vehicle, some cases where the *Nischay Yan* was available only one way, and in one case the *Nischay Yan* driver demanded money for a service which is supposed to be free. This issue also occurred in case of other government ambulance services, though as an exception. That *Nischay Yan* meant for public hospitals was availed to go to a private facility, as indicated here, is also a puzzle that needs deeper probing as well as closer scrutiny of collected data.

There are regional differences in the use of different means of transport. In Purulia, Birbhum and Dakshin Dinajpur respondents availed of *Nischay Yan* in large numbers, while respondents in Hooghly, the two 24 Parganas and Purba Bardhaman used the *Nischay Yan* in a fewer number of cases, and in Nadia the incidence of using *Nischay Yan* was very low. A total of 36 respondents stated that they used other means of transport; of which 9 had used other types of government ambulances, like the 102 service, while the rest used other local public transport like *toto* or private bikes (there were two cases of delivery at home).

The choice of facility for delivery depended on several factors. To an extent, respondents who have chosen to go to government hospitals for delivery feel that it is a more dependable choice, but another section also chose that option because they have no other facility available. Almost half the respondents go to government hospitals only because they cannot afford the charges of private facilities. At the opposite end, three-fourths of the respondents who have chosen to deliver their child in a private hospital or nursing home felt that private facilities were more dependable, especially in a situation like the pandemic. In a smaller number of cases, however, private facilities were availed only because there was no other option i.e., public health facilities were inadequate in the area. There were also a few respondents who said that they had availed private facilities for other reasons – the required equipment for delivery through Caesarean section was not available at the local public health centre, they were referred to far-off district hospitals but preferred not to go there due to the distance or difficulty of travel. In two cases the respondents said that the ASHA worker had advised them to go to a

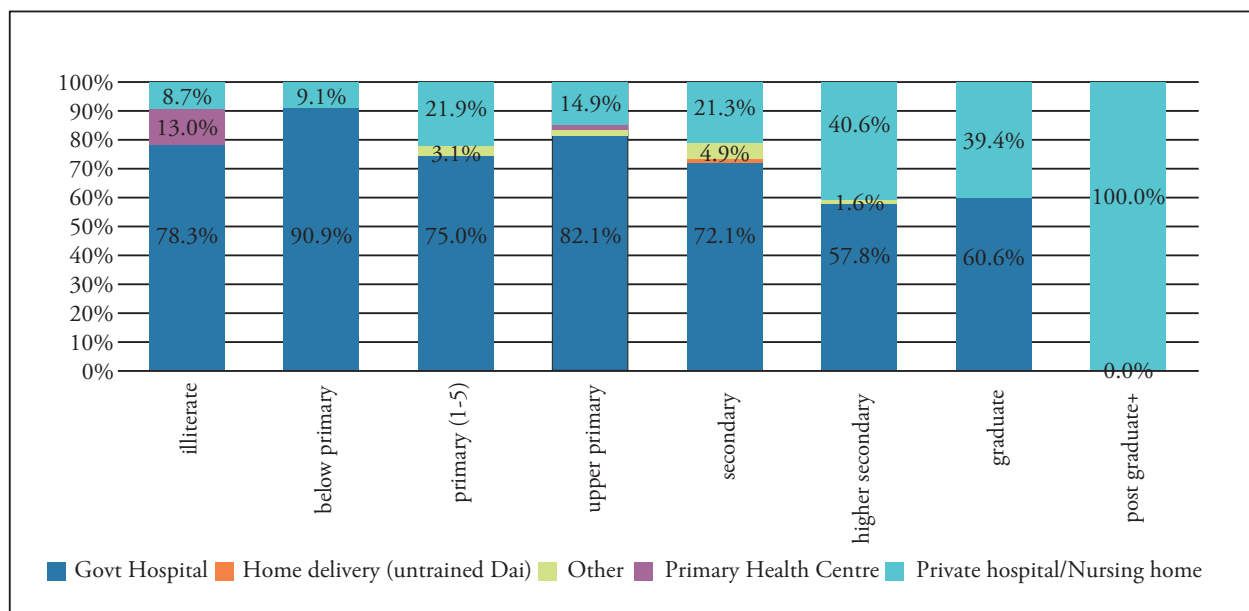
particular private health facility. Thus, choice of health facility depends both on perception and on prevailing infrastructure and facilities in the location.

Figure 3.2: Reasons for choice of facility for delivery



Source: Pratichi primary survey 2020

There appears to be a clear relationship between the respondent's education level and the choice of health facility for delivery. The perception of private facilities being better than government facilities appears to be more widespread among more educated households. As the Figure 3.3 shows, the more educated the respondent, the higher the chance of choosing a private health facility over a public one. Even then, the confidence of rural households in government health facilities is reflected in the fact that even among the highly educated respondents (with a higher secondary and graduate degrees) less than half have opted for private health facility.

Figure 3.3: Respondents' education level and choice of facility for delivery

Source: Pratichi primary survey 2020

The relation between income level of the household and the choice of health facility also reveals a bias in favour of private healthcare. We use household occupation (primary source of household income) as a proxy for household income. Broadly, households whose primary source of income is manual labour (agricultural or non-agricultural casual labour and regular wage labour) have been categorized in the lowest income bracket, while cultivators and sharecroppers could be considered in a slightly higher income bracket. Owners of petty business maybe clubbed together in this second category, while salaried employees and independent professionals fall into a third, the highest income category of our classification.

Using this, albeit somewhat arbitrary, categorization of occupations, we can see that households dependent on non-agricultural casual labour are the most reliant on government health facility. It is clear that these households cannot afford to pay for a private facility for delivery of their child; even then some of them have chosen to go to private healthcare providers. The reasons, as stated above, are largely that the public health set up in their area of residence is not equipped to take care of the relatively medically complicated delivery process. The other labour-based households, as well as cultivators, share croppers and petty traders

prefer government hospitals in the delivery process in a large number of cases. It is only in the case of the somewhat better-off households, earning through salary or income from independent profession that the preference for government health facility declines to a considerable extent. Here again, the reliance of households on government health care facilities is exhibited in the fact that even among such better-off households, at least half of them choose the public health care sector.

Immunization of Children

Another major responsibility of the first line health workers is to immunise the children periodically. This too was hampered, perhaps due to change of focus of these workers.⁵ While this was partly due to increase in the burden of extra work on the health workers which is evident in the data, another major reason in decline in immunization rate among children was due to the fact that the births were not registered in many cases.⁶ Vaccine hesitancy on the part of some parents in the overall environment of risk of COVID contagion may also have played a role in this respect. However, there are reports that suggest that by the end of 2020 the situation reversed and child immunization activities were resumed. Again, Anganwadi Centres, which apart from providing pre-schooling and nutritional supplements to children and the expecting mothers, were involved in vaccination too, but remained closed during the pandemic.

Among the respondent households, 57 percent children were born before the lockdown, 17 percent during the lockdown and 26 percent were born during the unlock period.

A large section of respondents were not aware of the immunization schedule. Many of them responded that all inoculations had been done in time, but on enquiring which of the vaccines were due, very rarely were they able to explain the schedule. Most responses were “we don't know which injections are given or

⁵ West Bengal appears in the list of states which have reported more than 40 percent decline in Bacillus Calmette-Guerin (BCG) vaccination during the first quarter of 2020. See Kumar, Sodhi, and Jaleel (2020).

⁶ As Table 3.4 suggests that there had been a decline of 16 percent in the number of deliveries registered in the second quarter of 2020 with respect to the same period of 2019, it is even higher at 18.9 percent when compared with 2018 figure.

when the next one is due” or “yes, we got the vaccination done in time when the health *Didi* told us to come for vaccine”. Obviously, given the massive strain on health care functionaries who were involved as frontline workers against COVID, coupled with lockdown-related transport issues, there were shortages that health care workers had to manage by delaying the vaccination schedules. In these circumstances and given the information gap, the immunization track record on the surface appeared to be quite positive. In both the lockdown and the unlock period, inoculations appeared largely to have been given in time, but as mentioned above, many respondents' information about the vaccination schedule depended on what the healthcare functionaries said.

There are some regional variations, when we focus specifically those respondents who reported delay in immunization process. Some of the districts – East Bardhaman and South 24 Parganas – had a much lower record of immunization during lockdown, and they picked up their immunization schedules during the unlock period. These two districts have a large gap between the extent of immunization during lockdown and during the unlock period.

In several cases, vaccination that was due during the lockdown period was taken during the unlock period. The major such cases were in Dakshin Dinajpur and Hooghly districts, while also some in South 24 Parganas. There are a very few cases – about 2 percent of all respondents – who said that they had not been able to get their child inoculated even post the lockdown period.

Vaccination schedules had been pushed back in a significant number of cases – some respondents of Dakshin Dinajpur and Hooghly stated that their child had been given only the vaccine pending from the lockdown period while the vaccination to be done during the unlock period was still due.

Various reasons were given, e.g. 'health facility remained closed during lockdown', 'health facility did not function properly even in unlock period' etc for delay in immunization (we have counted percentages from only those 92 respondents who stated that vaccination had been delayed in their cases). However, more than two fifth of these respondents reported that inadequate functioning of health facility during lockdown was the principal reason for the delay in immunization. That ASHA worker/health worker did not inform them

on time was stated as a reason by a few. In a few cases, due to child birth at home, relevant information was not communicated. In some other cases, the health centres were open but there was inadequate supply of vaccines.

These issues could provide an explanation for why our survey data indicates that vaccination was largely regular even during the lockdown, when other studies have indicated a downturn in vaccination in the same period.

While district-wise differences can be attributed to differences in efficiency, infrastructure and health resources in the functioning of the healthcare system, these are factors that impact supply of immunization. However, it is also important to study the relation between the social profile of the households, educational attainment of the respondents, and their economic background, to understand whether any variation in immunization achievement can be attributed to demand for immunization from the respondents' side.

In order to further look into factors determining the immunization responses, we looked at the relation between the main source of income of the household (as a proxy for income level) and the immunization schedule during lockdown. Further, we also analysed the education level of the child's mother to see whether it had any impact on the immunization schedule during lockdown. However, there is no substantial trend or relation found in these factors.

Since neither of these factors appear to have influenced the status of vaccination in the lockdown period, it is reasonable to conclude that purely external factors related to the interruption in smooth functioning of the healthcare system, have been responsible for the gaps in vaccination.

Social Effects

Apart from the RMNCH, COVID-19 had huge social effect on the people, especially the most vulnerable section of the society including women. There are apprehensions that a huge number of girls (3531683) will drop out of schools in India due to the pandemic (SickKids and Centre for Global Child Health 2021), resulting into increase in early marriages and adolescent pregnancies. The said UNICEF report estimates that due to the additional drop out mentioned above

due to the pandemic, there would be 235069 cases of adolescent pregnancies, which in turn result into 341 maternal deaths, 5893 neonatal deaths, a huge number of babies (90125) will be born with low birth weight and 16846 stunted children (SickKids and Centre for Global Child Health 2021). These figures are all in addition to already high rates of early marriages in India and the consequences thereon.

There are other reports which indicate towards a huge increase in early marriages. In response to a Right to Information (RTI) application to the Union Ministry of Women and Child Development revealed that during the lockdown period (between the months of June 2020 to October 2020) there had been an increase of more than 33 percent in the number of child marriages as compared to 2019 (Thomas 2021). Though the RTI application requested for a state-wise detailed figures, it was denied. State-specific information is still not available; however, it is well known the cases of early marriage of girls in West Bengal is one the highest among the Indian states, the effect of COVID-19 pandemic on the figures of early marriage in the state has in probability has increased. There are media reports related to spike in number of early marriages in the state (The Indian Express 2020, The Telegraph 2021).

In conclusion

It is difficult to draw definitive conclusions regarding the state of RMNCH services and its impact during the pandemic and lockdown. Certainly, services were impacted, despite being categorised as essential services. Transport difficulties were responsible for shortages of staff, materials as well as for difficulties in moving to healthcare facilities for delivery. In some cases, though not many, respondents reported that healthcare facilities were not functioning. The major impact was on frontline healthcare workers, who were engaged in various COVID-related activities and therefore often unavailable to fulfil their primary responsibilities in the maternal and childcare sector. While immunization appears, from our data, to have functioned relatively smoothly, the situation has to be juxtaposed against the information gaps that our respondents possibly live with and their dependence on schedules provided by primary health

workers. The observed decline in maternal and childcare services seems to have emerged due to a severe shortage of staff who were overstretched due to the pandemic.



Child immunization during the pandemic

Health as Security of Food and Livelihood: PDS and NREGS Revisited

Food security is crucial for wellbeing of people of a country. Ensuring food security for all is an agenda of the Sustainable Development Goal (SDG)-2. It states that food security will be ensured for all by 2030. India is a signatory to SDGs; however, its performance towards achieving the target is not very satisfactory. According to the Global Hunger Index (GHI)¹, it has made some progress but still the performance is quite poor. Based on percentages of undernourished population; under five children suffering from wasting (low weight for height), stunting (low height for age) and child mortality, scores are calculated and countries are ranked accordingly. Countries with score below 9.9 belong to the group of low hunger and the countries with scores between 20 and 34.9 belong to the group where hunger is of serious concern. India has improved from 38.8 in 2000 to 27.7 in 2020. Unfortunately, this is not very encouraging progress. As far as its rank in this respect in the world is concerned, India has been placed among the low performers. It has been placed at the position of 94 out of 107 countries in GHI 2020. Sri Lanka (64), Nepal (73), Bangladesh (75) and Pakistan (88) are ahead of India in 2020.

Hunger is a consequence of food insecurity. One of the consequences of hunger is malnutrition that appears to be a serious concern as per the findings in the fifth National Family Health Survey (NFHS). It reports a very high prevalence of malnutrition among children below five in most of the states of the country. What is more, the extent of malnutrition has increased as compared to what obtained in NFHS-4, five years ago.

Poverty may be one of the key reasons behind hunger and malnutrition since it may limit access to essential food. India has made significant progress in bringing down the extent of poverty. Still a substantial proportion of people are living below poverty line. The situation of the poorer people was under higher risk, in

¹ GHI is a peer reviewed annual report published by the Concern Worldwide and the Welthungerhilfe.

terms of falling in the trap of malnutrition, during the pandemic period since it has affected the employment market seriously and thus reduced peoples' income as well as purchasing power. In this context food support from various agencies, particularly the free distribution of food items through the Public Distribution System (PDS) by governments, is likely to play an important role. Contribution of the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) is also likely to be important in a situation where the functioning of the regular employment market has been severely disrupted. It is important to know whether these schemes have contributed to food and livelihood security during the pandemic season. If so, in what ways and how far have they reached out to the targeted people? This chapter explores answers to these questions.

Methodological Aspects

In order to explore answers to the questions delineated above, 500 interviews were conducted in the districts of West Bengal. The interviews were carried out over telephone during the period between October and December, 2020. The telephone numbers of the respondents were collected through various sources, but primarily through government school teachers. The respondents, with direct or indirect association with government schools that are peopled mainly with poorer children of society, represented the relatively underprivileged sections of the populace. At the time of sample selection attention was paid to a decent representation of various parts of the state as well as of the rural-urban sectors. Eleven districts were selected from the state (see the distribution of samples by districts in next page). Further, out of 500 samples, 400 were from rural locations, and the rest from urban sectors.

Table 4.1: Distribution of respondents by districts and sectors

District	Total	Urban	Rural
Bankura	40	0	40
Birbhum	60	20	40
Cooch Behar	40	0	40
Dakshin Dinajpur	40	0	40
Kolkata	60	60	0
Murshidabad	40	0	40
Nadia	40	0	40
North 24 Parganas	60	20	40
Purba Bardhaman	40	0	40
Purulia	40	0	40
Uttar Dinajpur	40	0	40
Total	500	100	400



Some Basic Socio-economic and Demographic Characteristics of Respondents

Due to the pandemic situation, the freedom of sample selection was limited. In spite of the difficulties in drawing up a socio-economically representative sample, we tried to ensure representation of different social, caste and religious groups in our sample. The characteristics of respondents are provided in the following table.

Table 4.2: Basic characteristics of respondents

Distribution of respondents by caste	:	Percentage
ST	:	13.0
SC	:	26.0
OBC	:	20.0
General	:	39.0
Others	:	2.0
Distribution of respondents by gender		
Female	:	22.0
Male	:	78.0
Distribution of respondents by religion		
Hinduism	:	69.0
Islam	:	29.0
Christianity	:	0.4
Santali	:	0.2
Others	:	1.4

Contd...

Primary source of household income		Percentage
Agricultural labourer	:	9.8
Artisan	:	0.6
Cultivator	:	27.4
Independent profession (lawyer, doctor, private tutor etc)	:	2.6
Non-agricultural labourer	:	20.0
Regular wage labourer	:	6.4
Salaried	:	7.8
Self employed (using mainly own labour)	:	15.0
Share cropper	:	3.2
Trade	:	0.8
Others	:	6.4
Relationship of respondents with head of the household		
Self	:	50.6
Child	:	23.8
Parents/parents-in-laws	:	9.4
Grandchild	:	0.6
Spouse	:	14.2
Spouse of child	:	1.0
Brother/Sister/Sister-in-laws	:	0.4
Distribution of respondents by educational status		
Illiterate	:	5.8
Below primary	:	7.6
Primary	:	13.6
Upper primary	:	26.0
Secondary	:	14.0
Higher secondary	:	18.4
Graduate	:	11.2
Postgraduate and above	:	3.4

PDS and MGNREGA in West Bengal: A Fleeting Glance

After the national lockdown, the distribution of rice and wheat, available under PDS, was made free of cost by the Government of India; but it covered only a part of population of the state. Government of West Bengal (GoWB) tried to cover the rest of its population by making special provision for food supply. Initially free distribution was arranged up to November 2020 and subsequently got extended up to June 2021. According to the National Food Security Act, 2013 (NFSA), which is implemented by the central government, only 67 percent of population is supposed to get the benefit of PDS and a variety of cards (AAY, PHH and

SPHH) have been issued accordingly. At the outset of the implementation of this Act, the number of beneficiaries was calculated, based on population in Census 2011 and the Socio Economic Caste Census 2011. The number of beneficiaries however has not been revised in tune with the subsequent increase in population size.

In order to provide services of PDS, the Government of West Bengal has introduced Rajya Khadya Suraksha Yojana (RKSY). It has divided the population, extending beyond NFSA coverage, into two economic groups and made arrangement for issuance of another set of ration cards, called RKSY-I (for poorer group) and RKSY-II (for better off group). The state government has made provision of distribution of food grains to them at subsidized rates accordingly. The amount of subsidy and the quantity of food grain available from PDS to them has varied depending upon the economic group (RKSY-I & RKSY-II) in question and has generally been lower than NFSA entitlements.

As far as the coverage of people under various categories of ration cards is concerned, the number of total beneficiaries under NFSA and Non-NFSA combined stood at 103003279 in West Bengal (Department of Food and Supplies, No date¹). The share of NFSA and Non-NFSA beneficiaries were 62 and 38 percent respectively. It appears that presently the share of NFSA beneficiaries is less than the target (67%). This is perhaps due to the mismatch between the increase in the number of beneficiaries and the increase in the size of the population during the period between 2011 and 2021.

Table 4.3: Entitlement of food grains from PDS by type of ration card

Category of ration card	Entitlement
AAY	15 kg of rice and 19 kg fortified atta or 20 kg wheat per family per month. 2 kg rice and 3 kg wheat per head per month upto December 2020 and one kg chola per family per month till January 2021 under the Pradhan Mantri Garib Kalyan Anna Yojana (PMGKAY)
PHH and SPHH	2 kg rice and 2.85 kg atta or 3 kg wheat per Ration Card per month. Under PMGKAY 2 kg rice and 3 kg wheat per head per month upto December 2020 and one kg chola per family per month
RKSY-I	2 kg rice and 3 kg wheat per Ration Card per month
RKSY-II	1 kg rice and 1 kg wheat per Ration Card per month

Source: Department of Food and Supplies (No date²)

Like in the case of the PDS, the Government of West Bengal appeared to be proactive in the implementation of MGNREGA too, at least in the recent past. While India, as a whole, provided 42 days of employment to a household, it was about 70 days for West Bengal during the year 2018-19 (GoI 2019). In the light of this brief overview of the background conditions, it is time to now turn to discuss our research findings.

A Few Main Findings

Dimensions of Food Crisis

Shortage in food availability and affordability indicates a basic form of crisis. Analysis shows that on an average 10 kg food grains per head or 47 kg per household per month was required, but only 29.7 kg per household was received. This suggests that a household had to buy one third of its required food supply [see more later]. Perhaps this was too huge a quantity for some families. That's why, nearly one out of five (19.4 %) households reported to have suffered from food crisis during the pandemic season.

Location of respondents has something to do with their felt need for adequate food supply. Twenty percent of rural respondents and 18 percent of urban respondents reported about an emergent food crisis. A possible explanation may be found in the primary source of income that a household survives on. The lockdown did not quite affect the income of salaried employees and pension holders. Twenty four percent of urban households in our sample were salaried, whereas it was only four percent among rural households. Similarly, 11 percent of urban households belonged to the category called 'other', whereas it was five percent for rural households. This category included pension holders, domestic workers, car drivers etc. Income of pension holders was not affected by the lockdown. The share of households that earned livelihoods by hiring out labour for non agricultural activity, which was affected severely, was lower in urban (14%) than in rural (21%) areas. So, all these factors might have contributed to making food crisis a bit less severe in urban areas.

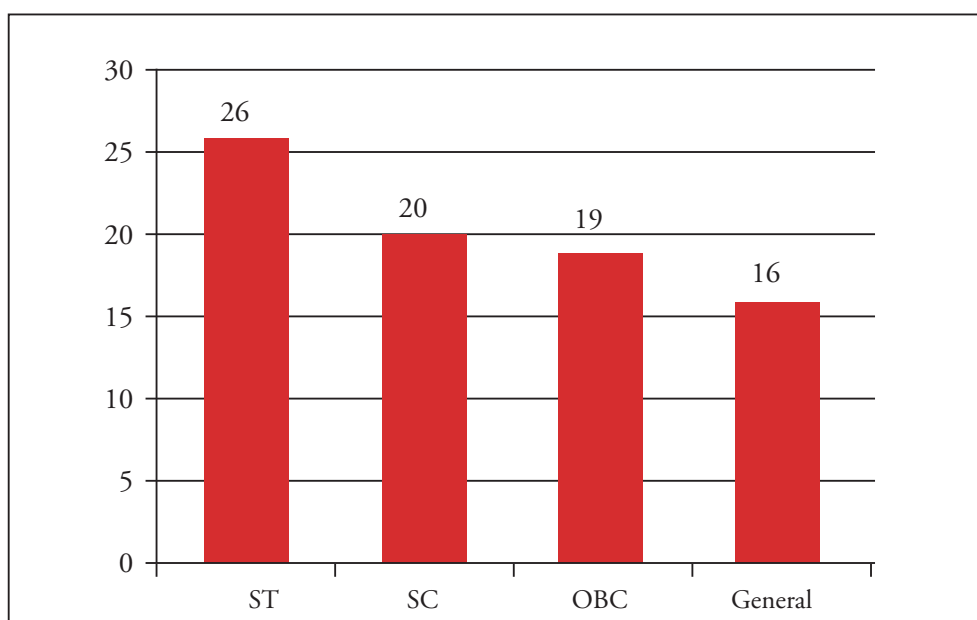
Table 4.4: Distribution of households (percentage) by primary source of income

Type of income source	Rural	Urban
Agricultural labour	12	0
Cultivator	34	0
Independent (lawyer, doctor, private tutor etc.)	1	9
Non-agricultural labour	21	14
Regular wage labour	4	16
Salaried employee	4	24
Self employed (using own labour)	13	24
Share cropper	4	0
Trade (hired labour) + Artisan	1	2
Others	5	11

Source: Pratichi primary survey 2020

Social Determinants of Food Insecurity

Further it was observed that caste was an important determinant of the felt intensity of food shortage. Households belonging to ST groups reported more about food crisis than their counterparts from any other social group. The proportions of such households were 26 percent for STs, 20 percent for SCs, 19 percent for OBCs and 16 percent among General caste groups.

Figure 4.1: Percentage of food-insecure households classified by social groups

Source: Pratichi primary survey 2020

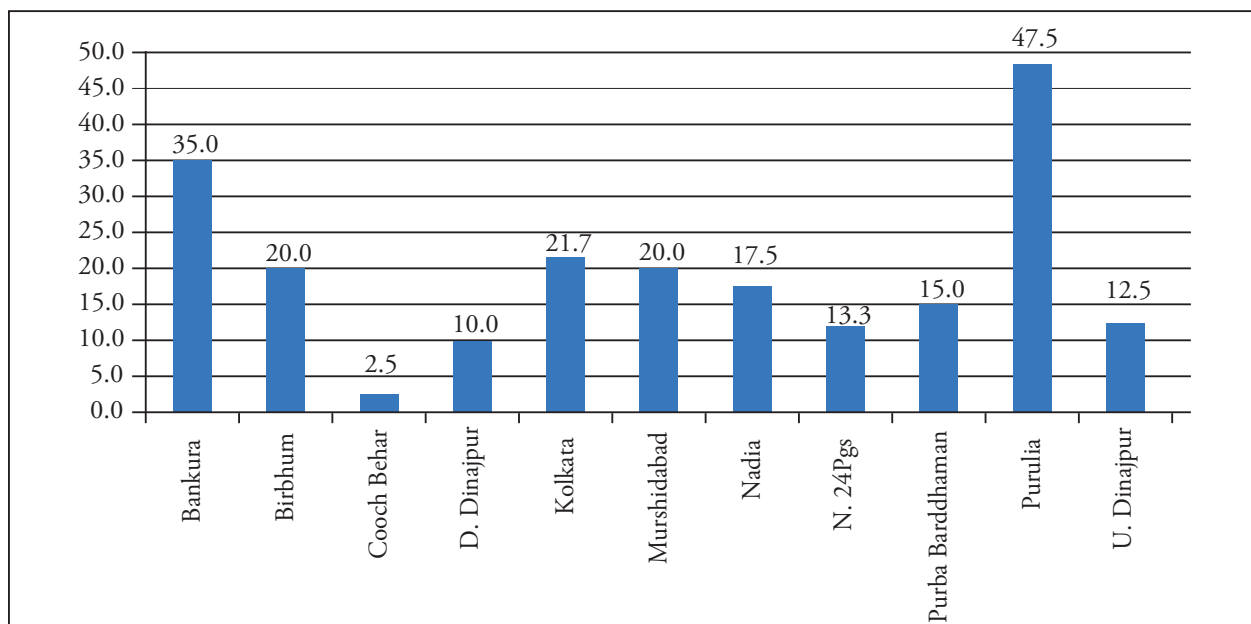
A number of recent studies point out the acute nature of livelihood crisis that urban sectors have been witnessing in different parts of the country post the lockdown. Hence the relative food deprivation of STs, who live mostly in rural areas, may seem intriguing. Further, cultivation, as the primary source of income, was found to be proportionately higher among STs (44%) compared to the corresponding figure for all other social groups taken together (34%). Apparently cultivation too was comparatively less affected when compared with other sources of income, especially those having to do with non-agricultural activities, with the exception of government jobs.

Deeper probing reveals that 77 percent of these cultivators were from Bankura and Purulia districts, where cultivation is largely mono-cropped and rain fed and the productivity of land is lower than that of other districts. Seasonal migration for agricultural activities was a characteristic of the people of these districts and this tendency is particularly pronounced among STs. Many of them survived on combined earnings from cultivation and migration. The lockdown drastically limited the scope for migration and correspondingly for their additional income. The lack of such supplementary income might have contributed to their relatively higher burden of food shortage.

Moreover, the percentage of STs (22%) engaged in non-agricultural activities, which were also badly hit in this crisis time, was higher than that for all other social groups taken together (20.5%). This also might have contributed to their special predicament in terms of food security. A district-wise map of food crisis also conforms to this scenario.

Food Crisis by Districts

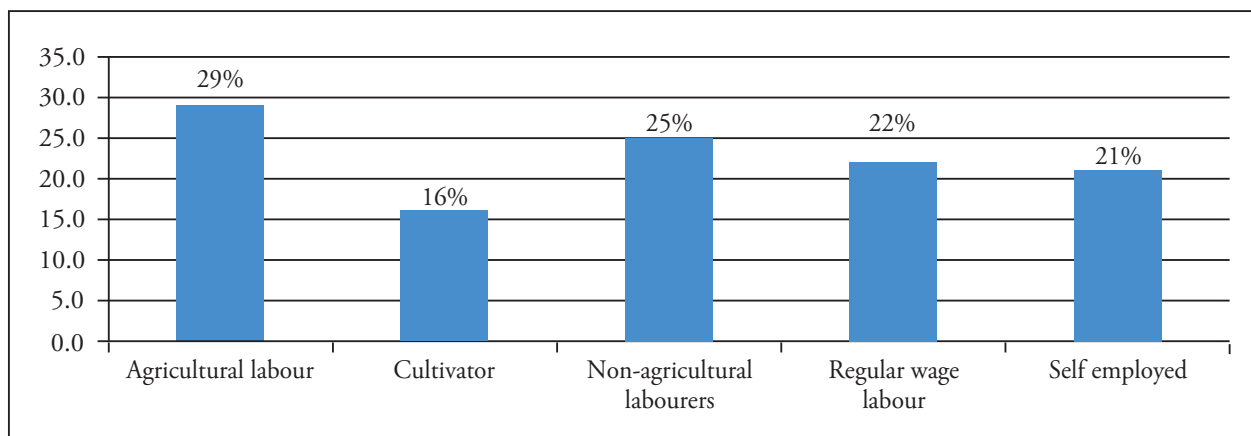
Suffering from food crisis was not uniform across the districts. The highest affliction was reported from Purulia (47.5%) followed by Bankura (35%). This is consistent with the findings of food crisis cross-classified by social groups as well. The lowest (2.5%) reporting of food crisis was from Cooch Behar district.

Figure 4.2: District wise reporting of food crisis (in percent)

Source: Pratichi primary survey 2020

Food Insecurity and Household Income

The source of household income likely matters in energizing or enervating people's resilience to deal with situations of food shortage. The households that reported food shortage the most (29%) were those whose primary source of income was hiring out labour for agricultural activities. This is followed by those that eke out a living by hiring out labour for non-agricultural activities (25%). The share of cultivators, regular wage workers and self employed in the total pool of food-starved households was 16, 22 and 21 percents respectively.

Figure 4.3: Source of income as a determinant of relative food insecurity

Source: Pratichi primary survey 2020

Persistence of the Crisis

How long the crisis lingered is an important aspect to consider. The longer the duration, the graver would be the impact on health. The food crisis, in our survey, appeared to have lasted for a variable time span. It was between four and 240 days. The days were considered from the day of imposition of the lockdown to the day of our interview. Twenty two percent of respondent households reported that their food crisis lasted for less than one month; forty five percent suffered for a period between 30 to 60 days, and 33 percent lived through food shortage for more than 60 days.

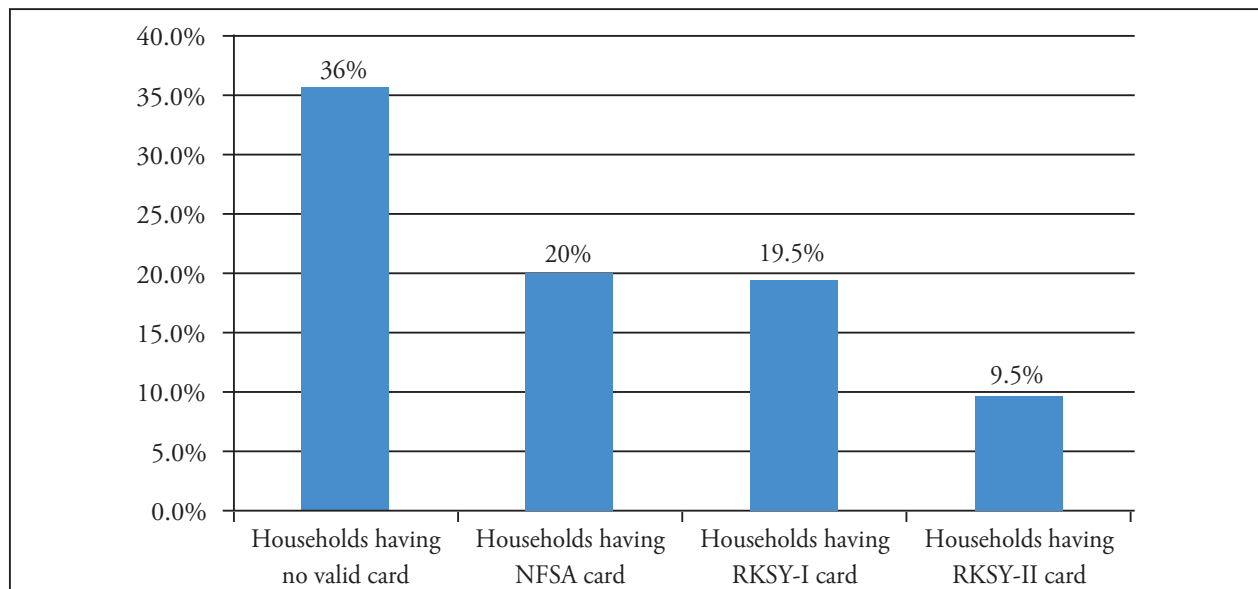
Type of Ration Cards and the Burden of Food Shortage

Since household entitlement in terms of quantity of food grains depended on the type of ration card that they possessed, it may be apt to look into the issue of variable PDS support more closely. Close to 98 percent households had either NFSA or non-NFSA category of ration cards; only 2.2 percent had neither. Instead, they had older versions of cards called APL (Above Poverty Line) and BPL (Below Poverty Line), which technically rendered ineligible for any benefits from PDS. The number of cards (NFSA and non-NFSA) in many households was less than number of family members. As a whole, 10 percent of the household members had no ration cards. Further, around 21 percent households had more than one type of ration cards i.e. a mix of NFSA and non-NFSA cards. Originally these households had NFSA cards but later on when they applied for a card for their new members they did not get the same type. Instead they were provided, if at all, with RKS-I or II cards. Thus the total entitlement these households were eligible for got reduced since entitlement under new cards was less than that provided under NFSA cards.

During the lockdown months, people were distributed food grains free of charge. This likely played a crucial role in ensuring a modicum of food security. It appears that the poorest category (i.e. AAY card holders), didn't report of any suffering from food shortage. A possible reason behind this may include the fact that the quantity of food grains they received under PDS was the highest. Public provisioning of food support for this category of card holders was the highest among all types of beneficiaries.

On the other hand, the households having no valid (NFSA and RKSy category) ration cards reported to have suffered the most (36%). In other words, the public food safety net turned out to be a critical element to avert hunger and starvation during this COVID-triggered pandemic. Food-related insecurity was less among NFSA (PHH and SPHH) card holders (20%). It was 19.5 percent and 9.5 percent for households having RKSy-I and RKSy-II cards respectively. The NFSA card holders were supposed to be poorer than those possessing cards of RKSy categories. So it appears that a combination of PDS benefits and pre-existing economic conditions of the households played a role in lessening suffering from the looming food crisis. NFSA card holders were indigent and could have suffered more than what they actually reported. In all likelihood, it was the food grains provided under the PDS that kept the situation under control.

Figure 4.4: Household food shortage by the category of ration cards



Source: Pratichi primary survey 2020

The households that had no NFSA or RKSy category cards, mostly earned their livelihood by working as daily labourers. On the one hand they were not entitled to PDS benefits and on the other hand they could not earn on their own because of the lockdown. Free food grains from PDS could have reduced their suffering. By default the NFSA card holders too were supposed to be from poorer sections of the society; but they did not articulate their plight of food-related hardship as much as the above category. On the other side of the register, the households belonging to

RKSY-I & II were better off economically as compared to the NFSA households and hence understandably had experienced a lesser degree of hardship. In short, only the relatively lucky ones could draw on their private resources; for the rest public support proved crucial in this crisis hour.

Performance of the PDS at the Grassroots Level

Adequate quantity of food grain is an important part of food security. In the survey, there were some questions aiming to collect information about quantity of rice/wheat received under PDS and that purchased from the open market. Taking the quantities together it was found that the quantity of consumption per household was 47 kg and it was 10 kg per head in a month. This (per head) amount conforms to the findings of Kumar et al (2009) but stands somewhat lower than the amount reported in Bajaj (2011), where per head food grains consumption was calculated to be 14 kg. On an average, rice/wheat received, from PDS, per card was 7 kg and per household 29.7 kg. This means a household had to buy about 17 kg of food grains from the market every month. So, average quantity of food grains that a household had to purchase was 3 kg per head.

Table 4.5: Consumption and availability (from PDS) of food grains

Consumption of rice/wheat per household	47.0 kg
Consumption per head	10.0 kg
Rice/wheat received from PDS per household	29.7 kg
Rice/wheat received from PDS per card	7.0 kg

Source: Praticchi primary survey 2020

The quantity of consumption of rice/wheat by a household depends upon various factors including family size, gender composition, place of residence (urban/rural), income status, and age profile of members etc (Nawani 1994). So, the quantity of purchased food grains varied across households for obvious reasons. At the same time it was observed that the purchased quantity varied across types of ration cards that these households possessed. It appears that the poorer the families, the lesser the quantity that they had to buy, as they received greater quantity from the PDS. This equity-enhancing substitution effect of the PDS came to the rescue of a number of households in these trying times.

Table 4.6: Quantity of food grains received from PDS by type of ration cards

Type of ration card	Average quantity received per family (kg)	Quantity received per head (kg)
AAY	36.8	8.4
PHH+SPHH	36.0	7.8
RKSY-I	22.0	4.6
RKSY-II	14.7	3.0

Source: Pratichi primary survey 2020

Table 4.7: Purchase of food grains from market by type of ration cards

Type of ration card	Purchased per family	Purchased per head
AAY	7.0 kg	1.6 kg
PHH+SPHH	16.5 kg	3.5 kg
RKSY-I	17.0 kg	3.5 kg
RSY-II	23.0 kg	4.7 kg

Source: Pratichi primary survey 2020

Chickpeas, in addition to rice/wheat, were also distributed from Fair Price Shops (FPS) from the second month i.e. May 2020 and it was supposed to be continued till January 2021. This provisioning was limited to NFSA card holding families only. Further, the concept of a household in FPS was different from that of an actual family. An example may be useful in this regard. Once, Y and Z were members of the family X. The cards were issued when they were together in a family. Later they got separated giving rise to three separate families. But they were still considered as a single family by the FPS and accordingly they together were entitled to one kg of chickpeas. This was received by X from the FPS and then shared between three families. However, sometimes entire amount was kept by X only.

Grievances and Mechanisms of Redress

Quality of food grain may be an important factor. The food grains may be useful only when they are edible. In a survey (of Pratichi) on PDS in another state in a different time it was reported that the available food grains were used mainly as fodder. If so, then it would not serve the purpose of providing food security. In West Bengal, only 7 percent of respondents told that quality of food grains was

bad. Almost all of the respondents were satisfied (45% said good) or partly satisfied (46% said moderate) with the quality of food grains provided under PDS. Less than two percent indicated that the quality was not always the same; rather, it varied between months.

Table 4.8: Responses on quality of food grains

Quality of food grains	Percentage of responses
Good	45
Bad	7
Moderate	46
Others	2

Source: Pratichi primary survey 2020

Food grains included, as shown in the Table 4.3, rice and wheat in the main and flour in place of wheat occasionally. People often complained about the quality of flour. Only a section of the respondents consumed it and the rest sold it to the street vendors, who purchased it from the households and in turn re-sold it to the vendors, operating from outfits situated in close proximity to the (FPS).

There were also some examples where the beneficiaries sold the rice available under PDS and purchased preferred variety of it from the open market. For example, *Swarna*, a variety of rice that was distributed by FP shops, was not popular with some beneficiaries and hence was sold or used upon mixing with some other variety of rice. However, such cases were comparatively few during the COVID crisis. The response on the quality of chickpea was to some extent different from that vis-a-vis rice/wheat. This is reflected in the following Table.

Table 4.9: Responses on quality of chickpeas

Quality	Percentage of responses
Good	56
Bad	17
Moderate	27

Source: Pratichi primary survey 2020

Comparison between Tables in above [Table 4.8 and 4.9] suggests that a greater number of respondents commented on the quality of chickpea as compared that of rice/wheat.

One of the questions in the survey was aimed to explore whether there was any problem faced by the beneficiaries in getting the food grains from the ration shop. Forty four, i.e. 8.8 percent, respondents reported that they faced some problems. Twenty two out of them had non-NFSA cards and this constituted 14.7 percent of all non-NFSA card holding households. In terms of percentages, the lowest level of complaints came from the PHH and SPHH card holding households (3%) and the highest from those having neither NFSA nor non-NFSA cards.

The nature of complaints received was diverse. A group complained that the quantity given was less than what their entitlement was, about which they however had no precise idea. For another group, the ration shops opened irregularly. Some complained that they did not get any pulses. In one case it was complained that a part of their entitlement was taken away by some political characters and this was in the first month post the lockdown. It may be noted here that some complaints may have some valid basis whereas some others did not. For example, non-NFSA card holders were not entitled to get pulses, but they grumbled anyway.

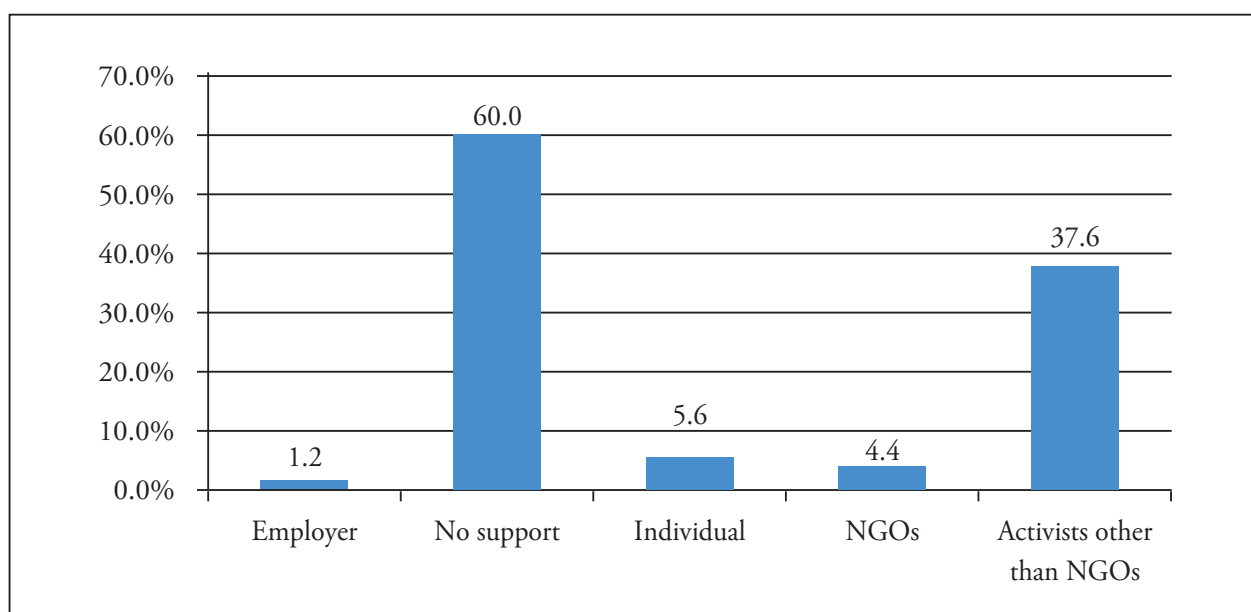
Though complaints were reported during our interviews, there was no evidence of people registering complaints with the concerned authorities. Perhaps it was not easy to do so. In a situation in which getting a ration card even after several visits to the concerned office was still hard, it was doubtful whether people would visit offices just to register complaints about receiving less than what was due to them. It was quite evident that people were happy getting some bagful of food grains free of cost. Often they didn't mind even if they were given somewhat less than what they were entitled to. Their feeling was like '*ja pachchhi tai anek* (whatever we get, that's a lot)'.

Further, in the official website of the state government, provisions have been made by the government to receive complaints from the general public. It provided phone numbers of different officials and also space for making written complaints. Surely, to realise this potential would require an active, informed and a decently literate citizenry – the condition that is not easily fulfilled in the midst of pockets of illiteracy in the state, poor network connectivity to ensure online registration of complaints, unavailability of technological devices and so on.

Food-grain Distribution by Other Agencies

In addition to PDS, several households benefited from food supply organized by other agencies, including other governmental departments as well as philanthropic agencies. The government schools and ICDS centres provided dry rations, once a month instead of daily cooked meals to the students enrolled there. Some NGOs, individuals and political agencies also offered free food grains and other necessary goods to the public.

Figure 4.5: Percentage of households that received food grains from non-governmental agencies and activists



(Responses were not mutually exclusive)

Source: Pratichi primary survey 2020

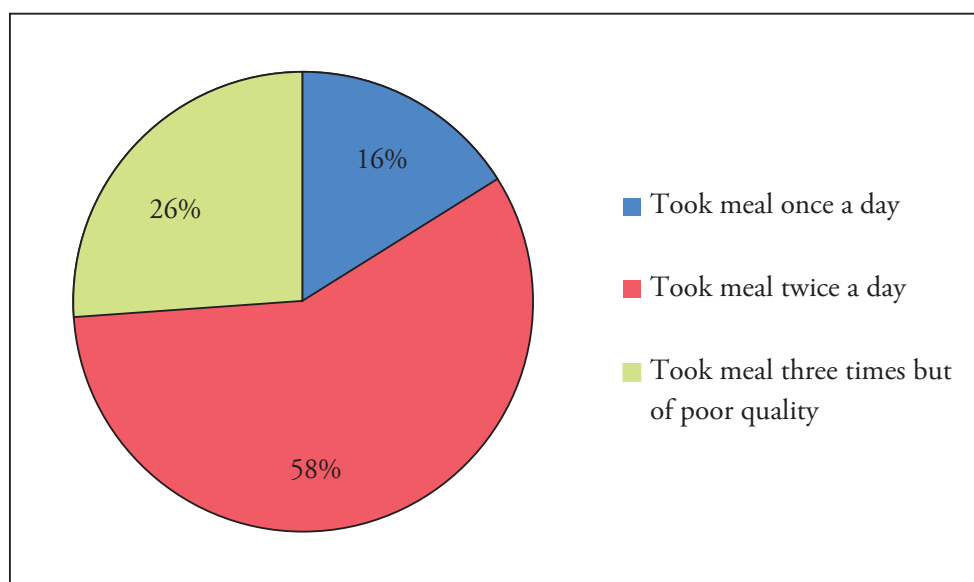
Strategies Followed by Individual Households to Manage Food Shortage

It was noted above that people had to buy a portion of food grain required for their families since only a part was available through the PDS. Purchase of the shortfall required money, as also purchase of some other important ingredients that constitute a decent diet such as spices, eggs, sugar, fish, meat etc. Different households adopted different strategies to cope with this imperative. Pinki Mandol of Dakshin Dinajpur district, for example, informed us that they would usually eat fish or meat 2-3 days a week during normal times. After the lockdown they had no fish or meat for four months. Similar strategy of cutting down on

consumption was followed by many other families, that were forced to give priority to just filling the stomach at the expense of nutritious food on their plate.

Managing the crisis took the form of not only compromising with quantity and quality of food but also of cutting down on the frequency of food intake during the day. In general, it was the adult members of the family who skipped meals. Among the households that faced food shortage (n=97), 16 percent reported that they took one meal as opposed to their normal practice of having three meals a day, 58 percent had two meals and 26 percent consumed food three times a day. Even the relatively fortunate households managing with three meals compromised with the quality of intake or with some members foregoing one or two meals.

Figure 4.6: Food consumption pattern of food-insecure households (n=97)



Source: Pratichi primary survey 2020

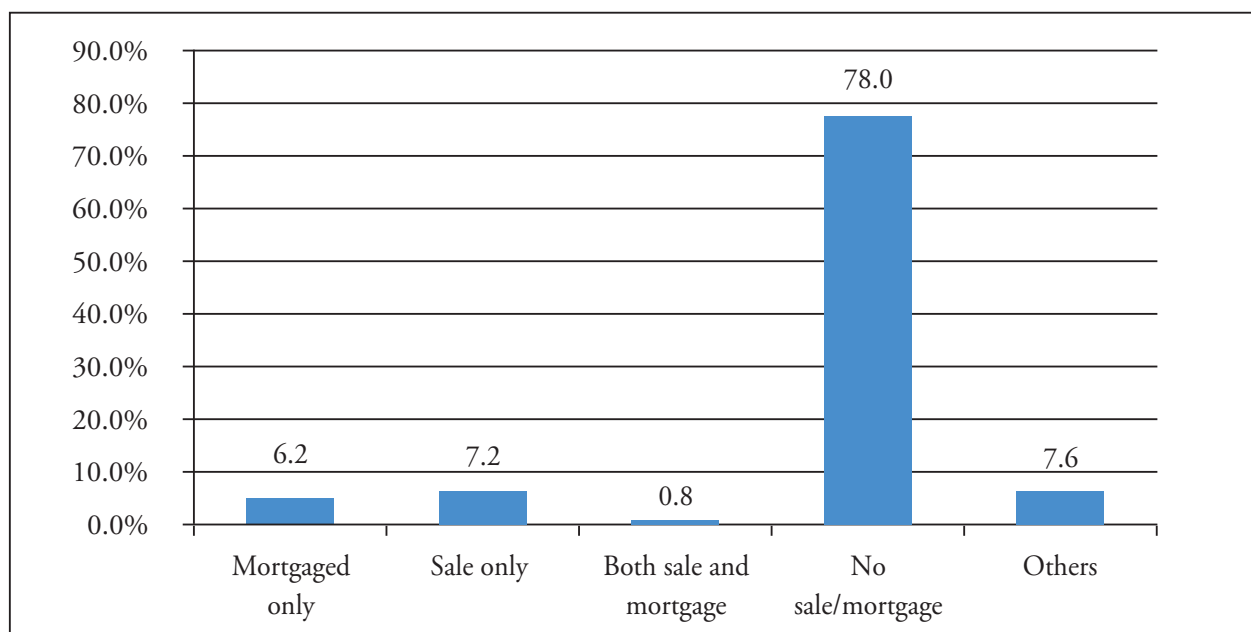
During this dire situation, the local grocers appeared to be greatly helpful. These grocers provided various necessary items including food grains, spices, tea, sugar etc. on credit. Savings of the people, though of meager amount, were also spent. There was evidence of distress sale of brass utensils, live stock as well as mortgage of gold ornaments, land etc. In some cases economically better off friends and relatives extended some loan to the less fortunate families. For some families the loan from microfinance and self help groups was also very useful. Often families

opted for a combination of strategies. Intriguingly, a number of such families did not report to us about their hardship.

Sale/Mortgage of Belongings as a Response to the Crisis

Out of 500 households 78 percent clearly reported that they did not have to go for sale or mortgaging of any assets or valuables to manage their needs during the COVID pandemic. But 22 percent were less fortunate than them. A section of them (6.2%) mortgaged and another 7.2 percent sold their belongings. Still some others (0.8%) had to do both, to sell and mortgage, some of their belongings, mainly gold ornaments. Still others sold their livestock cows, goats and poultry birds and natural resources like trees standing on their homestead plots. The money received from sale and mortgage was spent mainly on food items. A part of the money was spent on health care as well.

Figure 4.7: Proportions of households driven to sale/mortgage of valuables in response to the crisis



Source: Pratichi primary survey 2020

Contribution of MGNREGA to Food Security during the COVID Crisis

Tutul was able to return home in Purba Bardhaman district from Delhi only after he was sent some money, as bus fare, by one of his close relatives. At home he

was desperately looking for employment to meet the basic needs of his family. Similarly, Dhirendranath Bagdi, a casual worker of Indian Railway Catering and Tourism Corporation (IRCTC), had no earning since when train services got stopped. Though a large part of his food requirement, in the form of rice and flour or wheat, came from the government Public Distribution System (PDS), he needed some cash in hand – about rupees two to three thousand per month – to meet his basic needs such as medicines, edible oil, vegetables and spices, tea, sugars etc. He did not have enough money to meet these costs. So, only food grains are not sufficient to maintain a family. Cash in hand is important. But opportunity to earn money was severely restricted due to the lockdown.

Income during COVID-pandemic

It appeared from the present study that the COVID pandemic caused income loss for 87.8 percent of the households in various ways. Disruption in flow of income of a family may also lead to food crisis since it may dent its purchasing power.

Table 4.10: Distribution of households by impact of the pandemic on income

Type of impact	Percentage of households
Income reduced	57.4
No impact on income	12.2
No income during lockdown but presently working	27.2
No income since lockdown	3.2

Source: Pratichi primary survey 2020

The proportion of households reporting income reduction (a sub-set of the sampled households) is marginally higher (89%) in the rural sector than in the urban sector (87.5%).

Some earned less than their earnings in the normal times. Some did not earn any income during the national lockdown but started earning later on. And still another hapless section earned nothing since the beginning of the lockdown and this dire situation continued even at the time of our interview which was sometime between October and December 2020. More than three (3.2) percent

of the households earned no income during the period between the announcement of the lockdown and the day of the interview. They were mainly non agricultural labourers, with a few cultivators and agricultural labourers having the same fate. The respondent of one of such household was a worker of IRCTC. Since the trains, which he provided services to, were not in operation at the time of our interview, he continued to remain unemployed. The group of households whose income was not affected included grocers, cultivators (other than vegetable growers) and salaried employees, particularly government employees, and pension holders.

Income loss occurred even with some salaried employees as well. Abdul Salam and Soyel Islam of Birbhum district were two examples. The former was a technical staff in a construction company and the latter was a Business Process Outsourcing (BPO) worker. Both of them received only a half of their salary during the period of the complete lockdown.

Occupational patterns suggest that more than 40 percent of the households earned their income from agriculture as cultivators, share croppers or agricultural labourers. Income of cultivators in West Bengal in general is not very high particularly because of the small size of land holding on an average. Average size of land holding is 0.77 hectares and 96 percent of cultivators were small and marginal farmers in the state (GoWB, No date).² Though rice cultivation is common everywhere in the state, a part of cultivators grew vegetables for commercial purpose. During the lockdown the marketing opportunity for vegetables went down. Consequently many of the cultivators incurred loss and some others stopped cultivation altogether anticipating marketing difficulties. Bikash De of Birbhum district was a case in point, who did not grow vegetables apprehending losses and kept his entire land (2.5 bighas) fallow.

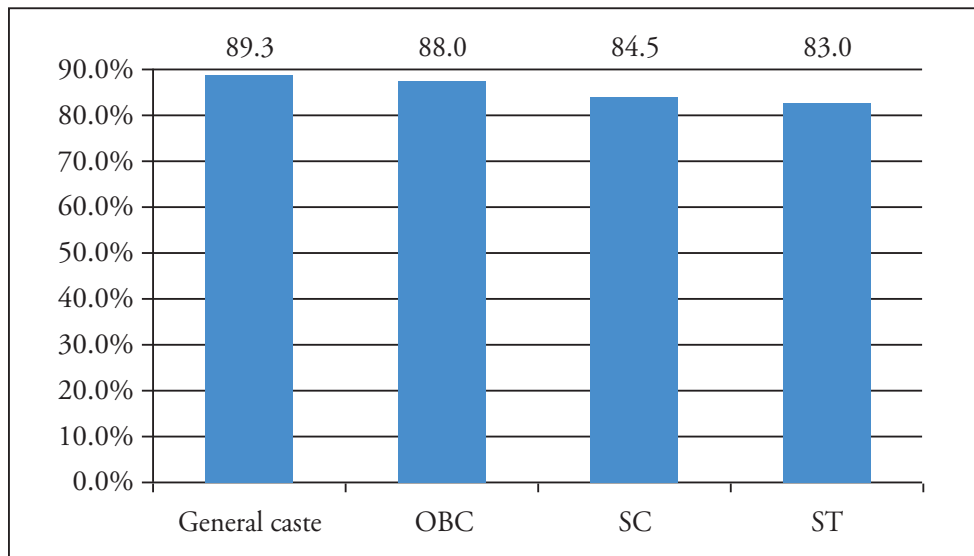
Non-cultivation affected not only the income of cultivators but also of many agricultural wage workers relying on cultivation and subsequent marketing of the produce.

Caste wise analysis shows that income losses were widespread among the members of General Caste groups (89.3%), followed by OBCs (88%), SCs

²Also see, Department of Economic Analysis and Research (No date).

(84.5%) and STs (83%). One of the reasons for the relative respite enjoyed by STs may be due to the fact that the first round of the pandemic did not badly hit agriculture comparatively speaking, on which they mostly depended. Further the General Caste group is less disadvantaged than the STs in terms of ability to address the challenge of income shock because of their favourable position in the economic strata. Perhaps that's why complaint of food crisis was higher among STs than General Castes.

Figure 4.8: Caste-wise distribution of households reporting income losses



Source: Pratichi primary survey 2020

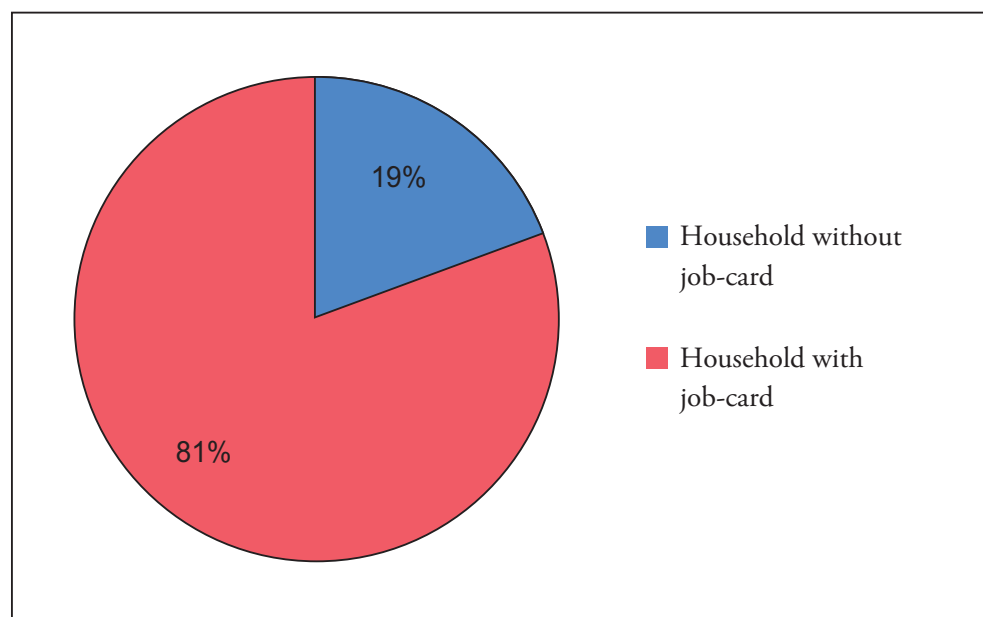
The food grains, available from PDS, was of great help to the people of West Bengal as elsewhere in India. It is good to know that 26 percent of households (n=132) did not buy any food grains from the open market. [Primary source of income of majority (58%) of these households was either cultivation or share cropping. So, perhaps they supplemented the requirement of food grains from their own cultivation.] But about three fourth of the households (n=500) had to buy it from the open market. This additional amount of food grains was purchased with the money from savings, loan, sale and mortgage of belongings or through other resources. But all these were only to manage the short-term needs. After a few days people were desperately looking for an opportunity of employment so that they can meet the essential needs with earnings. Since the existing employment market was severely affected, the employment potential

under the MGNREGA seemed vital, particularly when the average income earned by a household under this scheme was quite substantial (average Rs. 4000, median value Rs. 2600 and highest Rs.14076). This was an important earning option for the families that desperately needed some cash to buy items of top most priority. It is apt to mention here that the wage rate provided under MGNREGA work was Rs.191 and Rs.204 per day during the financial year 2019-20 and 2020-21 respectively. Reportedly, towards the beginning of FY 2020-21 the respondents received Rs. 191 per day and then Rs. 204.

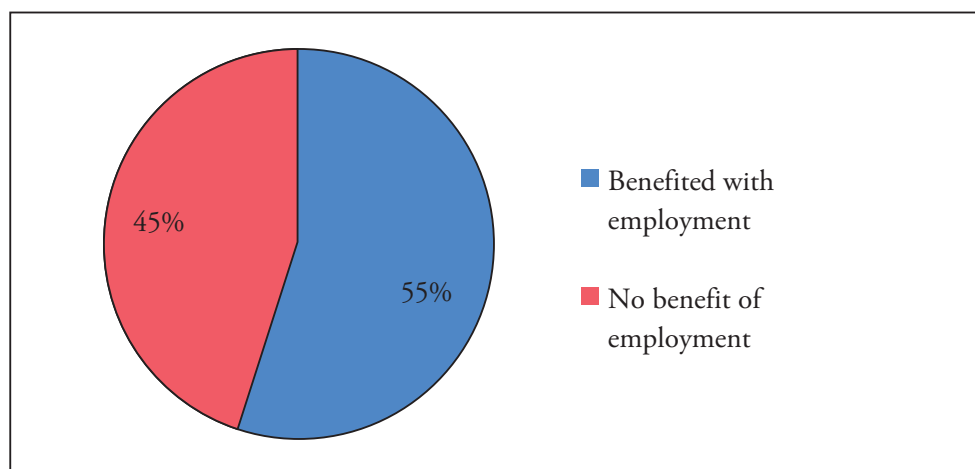
Extent of Employment Offered

Name of a member of a household in a job-card was essential for right of entry to employment under MGNREGA. This programme was meant for rural residents only [thus the urban respondents have been excluded from our analysis related to NREGA]. The sample size for the rural area was 400. About one out of five (19%) of them had no member with his or her name in a job-card. Among the job-card holding households only 55 percent reported that they got some employment. This means quite a large proportion of households (45%) did not get any employment.

Figure 4.9: Percentage distribution of households by job-cards



Source: Pratichi primary survey 2020

Figure 4.10: Employment opportunities for job-card holding households

Source: Pratichi primary survey 2020

The average number of employment-days for a household, who got some employment, was 23, during the period of nine months between April and December 2020. This figure comes down to 13 days if all job-card holding households are taken into account. April and May were the most trying months for the people. But only a small proportion of households reported that they were offered employment opportunity during that period. One of the reasons behind this might have been to avoid crowding, that would likely result from working together. Both from the demand side of the households and the supply side of the government, this concern could have led to some hesitancy. But the employment offered during the subsequent months was not much laudable either. A sizable section (39%) of the respondents from job-card holding households stated that no work was undertaken in their areas in the period under study.

Table 4.11: Distribution (percentage) of responses about NREGA work*

No work since lockdown	39
Worked since April 2020	12
Worked since May 2020	18
Worked between June and December 2020	31

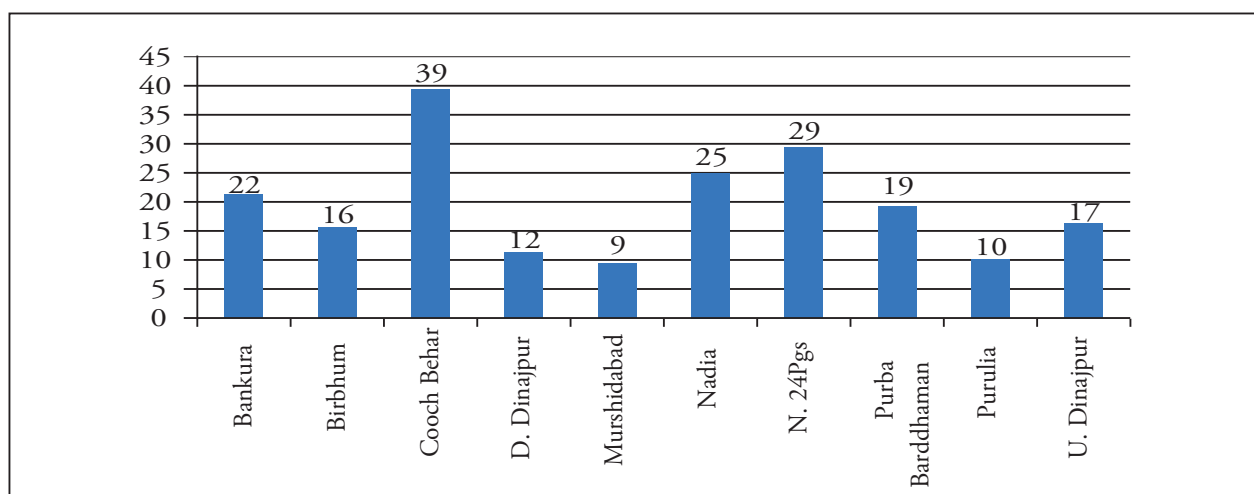
Source: Pratichi primary survey 2020

*Percentage was calculated from among the job card holding households (n=325) only.

The distribution of person-days appeared to be highly uneven. A total of 4175 person-days were distributed among the beneficiary respondents. But only 26 percent of the households under question got 50 percent of these person-days; the remaining 50 percent of person-days created was distributed rather thinly among 74 percent of the households in the reference group.

Further, it appeared that NREGA work was executed unequally across several tiers of administrative units, including villages, blocks or districts. District-wise, average person-days created were the highest in Coochbehar (39) and the lowest in Murshidabad (9). Respondents of Beldanga-II block in Murshidabad district reported that the NREGA work took place three long years ago.

Figure 4.11: Average number of person-days of employment created across districts



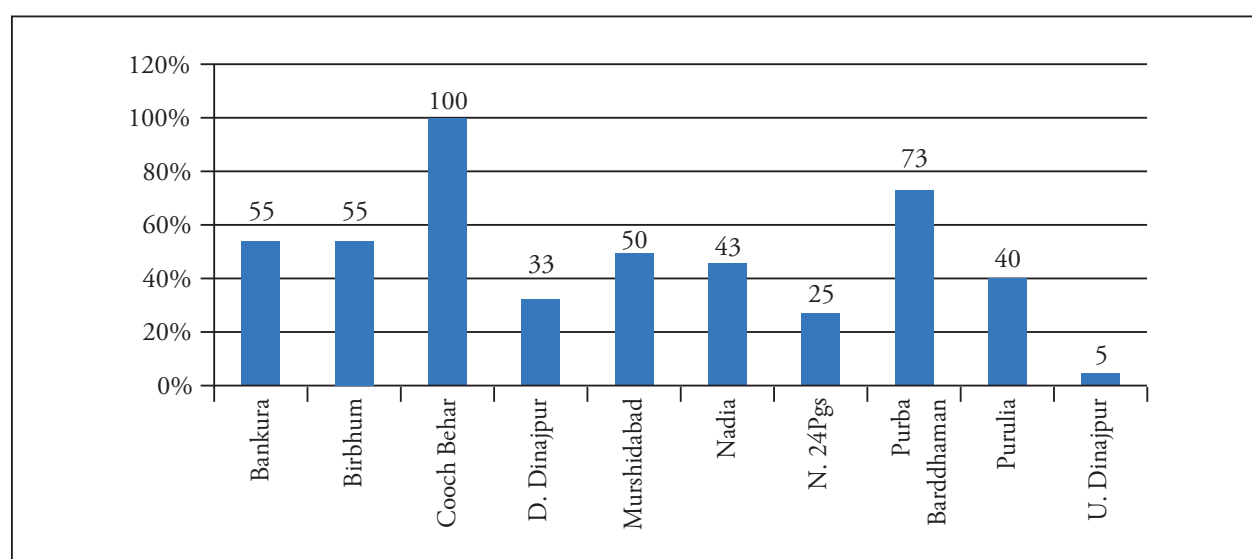
Source: Pratichi primary survey 2020

The unequal distribution between blocks in the same district also becomes apparent in some instances. It appeared that the respondents of Bolpur block got higher days of employment than of Nanoor Block of the same district (Birbhum). Similarly, the number of days of employment across two villages in Aushgram-II block in Purba Bardhaman district was also uneven. Even intra-village differences in the distribution of employment-days between households were palpable. Often it was alleged that the persons with close connections with executing bodies had greater chance to get employment opportunity under this scheme. The process of initiation and execution of a particular project under this scheme is of special

interest in this respect. According to our respondent Lakshiram Murddy of Birbhum, tokens were distributed one or two days ahead of the execution of a work. The brother of Lakshiram never got such a token though he too had his name in the same job-card and thus never got employment under that programme. On the other hand, Lakshiram believed that his relationship with the local panchayat member was a catalyst behind his getting this work.

The proportion of sample households which benefited from NREGA employment, also varied across districts. All of the respondent households in Cooch Behar reported that they got some employment under NREGA, but the corresponding figure was only 5 percent in Uttar Dinajpur.

Figure 4.12: District-wise proportion (%) of households that received employment



Source: Pratichi primary survey 2020

Limited Access to MGNREGA Work

As indicated above, there were respondents who did not get any opportunity to work under this programme. They were deprived because either they did not have job-cards, which was essential for the purpose, or did not get it even though their names were enlisted in one of those cards. The former occurred because issuance of job-cards fell behind the pace of demands that were generated. The latter possibly occurred due to the fact that the job cards under question, which were issued long ago, were in the custody of another family. This happened particularly

with those who, at the time of the preparation of a job-card, were in a single family which, afterwards, got split into a number of families. In those cases the concerned card remained with one of those families, often with parents or one of the brothers, restricting release of benefits to the custodian family only.

The beneficiaries of the government housing scheme, namely the PMAY(G) i.e. the Pradhan Mantri Awas Yojana (Grameen), particularly those who received the benefit during the last one year, were unable to get any opportunity of employment from the MGNREGA programme. According to the guidelines of PMAY (G), its beneficiaries are not only supposed to get the scheme value of housing, but also wage of 90 days from the NREGA programme. The total wage is supposed to be released proportionately with the release of installments of the housing scheme. Yet, many PMAY beneficiaries did not get their share of wage under the NREGA programme. Nor were they allowed to take part in the ongoing NREGA work. In one instance, a woman was 'mistakenly' allowed to take part in an NREGA work; when the 'mistake' came to the notice of the executive authority, the woman was asked not to continue. She did not get any wage for 12 days of work that she completed under this programme. This was because her father received a house under the PMAY(G) in the last year. But this woman got separated from her father long ago and was living alone and hence was deprived of this benefit.

Payment of Wage

Payment of wage was also an important concern. In Birbhum it was observed that the days for which a person got employment at a stretch ranged from 4 to 13 days. In other districts too, the beneficiaries got employment in several slots. Payment of arrears of wage was also made by slots. Often the gap between the two slots was more than one month. Everybody got their arrears of wages of one slot at a time. In all the cases this was transferred to their bank accounts. On an average a beneficiary had to wait for 20 days, with a minimum and maximum wait of 4 to 90 days respectively. Further, often the beneficiaries could come to know about the payment several days after their wage had been credited to their account.

Some of the respondents, however, pointed out that the delay in wage payment

got reduced post the lockdown in comparison to what transpired in the pre-lockdown period.

Concluding remarks

In order to contain the spread of COVID-19 infections the Government of India imposed a countrywide lockdown on March 24, 2020, with a four hours' notice. This led to the stoppage of almost all sorts of activities in the employment market, posing challenges to various aspects of life including food security of the people of the country. Among the measures to address this challenge, the governments made provision for free distribution of food grains (rice, wheat, flour and chickpeas) through the Public Distribution System. In addition, there was an added emphasis on the implementation of the MGNREGA programme so that some cash came in the hands of the rural people, enabling them to purchase basic things that they required. Based on primary data, this research reflects the contributions as well as shortcomings of the PDS and the MGNREGA in making a difference to the lives of common people during the pandemic.

According to the findings of this study, one out five households faced some food crisis. The duration of crisis varied between 4 and 240 days. A majority of these households suffered for about 60 days.

The data was segregated to lay bare different socio-spatial dimensions of these households. It appeared that reporting from rural areas was marginally higher than that in the urban areas. This was largely because the sources of income in urban areas were more stable. A higher proportion of urban households had income from salary and pensions.

When social groups are taken into account, reporting of food crisis by Scheduled Tribes was higher than that by any other social group. Association with underdeveloped agriculture, petty non-agricultural activities and migration seemed to have played a role in this regard. In the so-called normal times, poor income from cultivation could have been supplemented by non-agricultural activities and seasonal migration; but both these avenues got restricted during the lockdown period.

District effects also appeared as important determinants of the food crisis. The highest cases of food shortage were reported from Purulia and Bankura, the two most resource-starved districts of the state. Such reported cases were the lowest from Cooch Behar. It may be noted here that Cooch Behar was the best performer in terms of the creation of employment days and their allotment among the people under the NREGA programme.

The proportion of food-starved households would have been higher, in the absence of free distribution of food grains. To mitigate such conditions, free food grains were distributed by ICDS centres, schools, philanthropic organizations and individuals; but an augmented PDS was the most important intervention in this respect that provided larger quantity of food grains, with an almost universal coverage. Households without valid ration cards were most vocal about the emerging food crisis. Households with AAY cards, eligible for highest amounts of benefits from PDS, were more food-secure and hence made no complains about it.

The coverage of population of the state by the scheme sponsored by the central government (NFSA) was noticeably lower (57%) as against its target (67%). The initiative of the Government of West Bengal to cover rest of its population under the PDS through another set of cards proved crucial. Provision of ad-hoc benefit of free food grains was also made through a coupon system for those who were yet to get ration cards or needed it in any case.

To be sure, free distribution of food grains met only a part of the need of a household. On an average a family consumed 47 kg of food grains per month, while they received only 29.7 kg through PDS. A majority of households had to buy a part of food grains required for their families. Households with different types of ration cards had to buy different quantities of food grains. AAY card holding households had to buy the lowest quantity of food grains.

People needed money to buy required food grains along with some other basic things like spices, tea, sugar, medicines etc. Due to the lack of employment, a group of people could not afford it and consequently were forced to compromise with their food intake. Another group of people managed it by spending their savings, incurring loan from friends and relatives, and or by selling and/or mortgaging available resources like gold ornaments, livestock, trees etc.

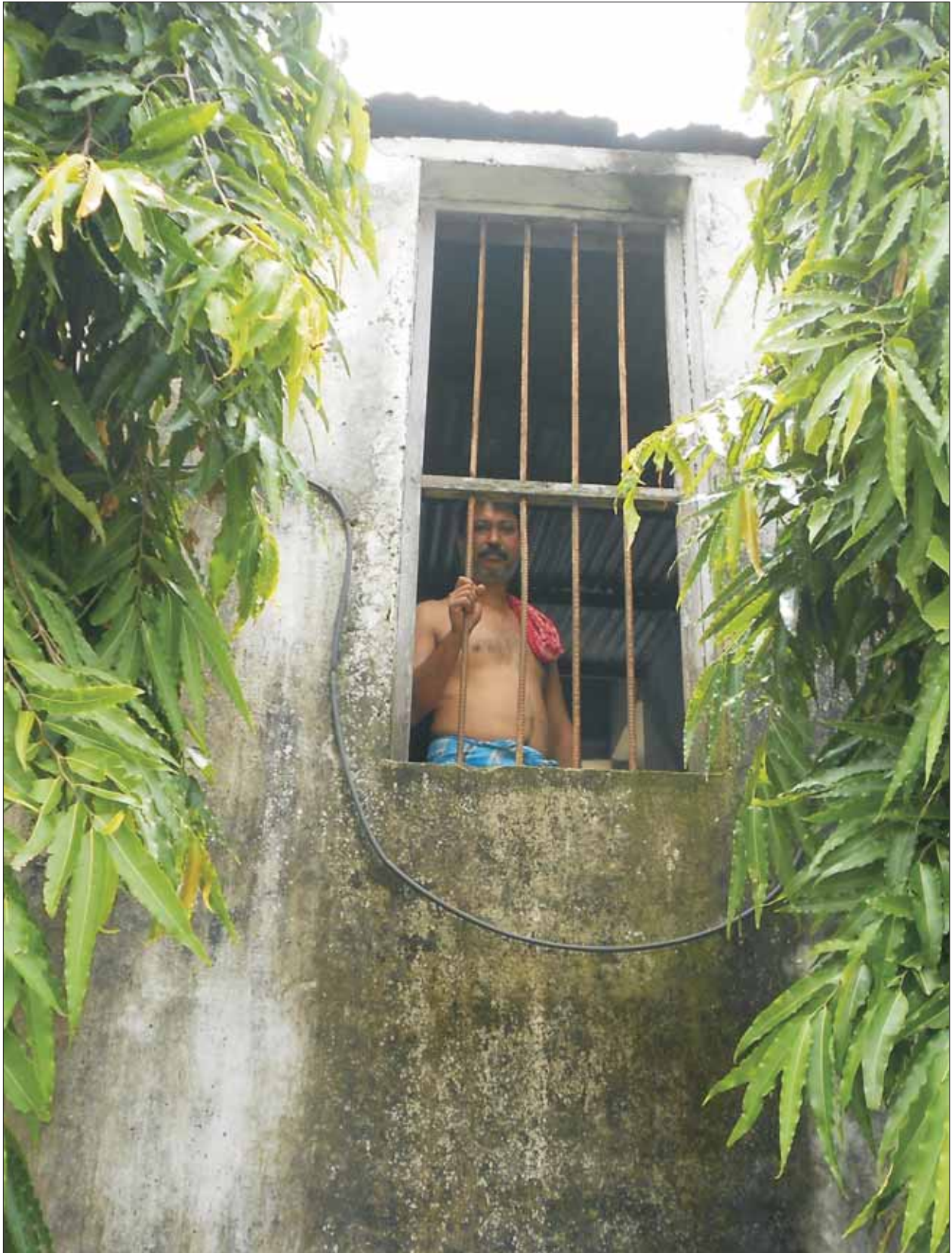
Local grocers appeared to be very helpful for the people dealing with the challenges of food crisis. Often necessary food and non-food items were available from them on credit.

Employment under NREGA was supposed to serve as another source of mitigating food crisis via access to some money. On an average a household having a member with a job-card got 23 days of employment during the period of nine months under review. This seems to be unsatisfactory performance particularly when employment opportunity in the open labour market was meager due to the COVID-19 crisis. This stood out in contrast to the past performance of the state with respect to creation of employment days. Against the national average of 50.9 days a year, West Bengal created more than 77 days of employment during 2018-19 (Government of India, 2021). It needs underlining however, that several studies report significant wage payment delays caused by delayed transfer of the same by the Central government. During most part of the period under review, such delays have been recorded in a significant number of cases for the state of West Bengal, possibly signifying that the observed decline in employment days under the NREGA in recent times in the state is a consequence of insufficient fund transfers (Goyal and Tamang 2022; Narayanan and De 2021). While during 2018-19 most states lagged behind West Bengal in terms of generation of employment days under the NREGA, whether the employment protection in this state has also been more robust in crisis times than in the rest of India is difficult to establish due to the paucity of comparable data.

The employment days were not allotted equally among the beneficiaries. A half of total employment-days was provided to 26 percent of beneficiaries, whereas another half catered to 74 percent of beneficiaries.

Inequality prevailed between districts as well. For example, a beneficiary household of Cooch Behar got 39 days of employment whereas it was only 9 days in the case of Murshidabad district. Similar anomalies were noticed between blocks in a district and between villages in a block.

Uneven creation of employment days was also noticed. While all the respondents of Cooch Behar reported that they worked under NREGA, the corresponding figure was only five percent in Uttar Dinajpur (n=40 in both the districts).



A migrant worker quarantined in a government school

'No Lockdown for Them': Crucial Role of Frontline Health Workers

This section deals with the experiences of frontline health workers including the ASHA (Accredited Social Health Activist) workers and ANMs (Auxiliary Nurse Midwives), with a particular focus on their critical role in dealing with the COVID-19 contagion in West Bengal. Unlike in several other states, Anganwadi Workers (AWWs) were kept out of COVID- related duties in this state; hence this study focuses only on ASHAs and ANMs.

Frontline Health Workers in Their Routine Role

The community outreach programme called ASHA was introduced as part of the National Health Mission in 2005. The members of this cadre are considered 'as an interface between the community and the public health system', entrusted with responsibilities to help rural and semi-urban communities to gain access to health-related services. In 2011 the government had claimed to have posted 'one ASHA in each village', with the charge to cover 1000 population. In reality, the population they cover is higher in a densely populated state like West Bengal.

According to data available on the website of the Ministry of Health and Family Affairs, there are at least 10,22,265 ASHAs in the country (Press Information Bureau 2020). In West Bengal, RTI data reveals that there are 53,485 ASHAs in 28 Health Districts.¹

The primary eligibility criteria to serve as an ASHA worker are that she is “A married widowed/divorced woman, preferably in the age group of 25 to 45 years, with education qualification of class 10”. According to the policy document of the National Health Mission, she is categorized as a 'voluntary health worker' (National Health System Resource Centre 2011). Her involvement in field-based

¹ Memo No HFW-27011/221/2020-NHM SEC Dept of H \$ FW/558, RTI application filed by Sabir Ahamed dated 05.12.2020.

interaction with mothers is thought in official parlance to be continuing for merely 3-4 hours in the same village that she lives in. Their work entails a wide array of activities including building awareness of the government's family planning policies, along with facilitation of programmes on maternal and child health. Aside from their routine work during 'normal' times, they are periodically entrusted with a wide range of works, including that of assisting the general administration in awareness building on various issues, in correcting electoral rolls, and during natural disasters.

The origin of ANMs dates back to 1952 as a cadre for addressing maternal health, midwifery and child health services. In the early years, they were treated as primary agents of family planning services. Their role expanded in the 1970s which include a plethora of preventive and curative health activities at the village level.

An ANM is posted at the sub-centres to oversee the well-being of the mother and the child, and areas that fall under a sub-centre comprises a few villages, thus constituting the ANM's field of work. Before the introduction of the National Rural Health Mission, there had been one ANM per one sub-centre. With the widening of the scope of health services at the village level under the Mission, however, the second ANM was introduced as a contractual frontline health worker. Like ASHA workers, they too are selected from the local community.

Network of Collaboration

What motivates us to examine the role of the ASHA workers during the pandemic includes in particular the continued dialogue that Pratichi (India) Trust has been having with the frontline health workers for several years now. They have regularly participated in the annual workshops of the Pratichi (India) Trust, and shared with other participants their quotidian experiences – rewarding as well as challenging – in enhancing community-level health services. They have often regretted that there is no platform where they can articulate their concerns and their own thoughts and suggestions for service delivery distilled in light of their grassroots involvement. Even during the national lockdown, some of the ASHA workers did informally interact with our team members, conveying their work-related fear and anxiety under such exceptional situation, taking a toll in turn on

their mental well-being. To further develop an understanding of the trials and tribulations of their working life during the pandemic-triggered crisis, Pratiche organized an online discussion meeting. The aim was to listen to the 'challenge-fraught yet high-spirited voices of a large group of frontline healthcare workers from different districts of West Bengal, including ASHAs, ANMs, AWWs, and district-level health counsellors' (Pratiche Research Team, 2020). The discussion laid bare the lived experiences of community health workers during the peak of the first wave. The conversation revolved around a wide range of issues including the challenges they faced, how they were forced into action without adequate protective gears in the initial days, how the health system was overwhelmed with the surge of cases, and consequent disruption of routine activities, and yet how they were saddled with additional mandatory family visits and duty at temporary quarantine centres set up for the returnee migrant workers. Their anecdotal accounts motivated us to undertake a telephone survey to capture the experiences of frontline health workers in a more systematic way. They were generous in sharing their experiences with us amidst their gruelling work schedule during the initial phase of the pandemic. We have interviewed around 140 frontline health workers, drawn from 13 districts.

Voluminous Workload of 'Voluntary Workers'

The pandemic and the subsequent lockdown have brought to light the importance of health workers (ASHA, ANM) as the frontline actors in the fight against the Corona virus. During the national lockdown, their work included conducting door-to-door health surveys to identify chronic diseases (like hypertension, diabetes, kidney or heart related issues etc.), carry out community awareness campaigns, identify COVID patients and test them. Their work also included maintaining quarantine and isolation centres, as well as following up on whereabouts of migrants.

This section is divided into three parts. The first part gives details of their expanded population coverage, and their increased load of activities, long hours of work, as also how they were thrown into action without proper training. The second part addresses the issue of their protection and incentives for their extra

and extraordinary work during the pandemic. Finally, some reflections and concluding remarks are presented.

Outsized Outreach

As we have indicated previously, the ASHA worker is expected to cover an area roughly peopled with 1000 population. In practice, the population they cover is higher in a densely populated state like West Bengal. Their assigned outreach has significantly expanded during the pandemic time. Our primary survey indicates that they are covering close to twice the population they are supposed to cater to during these difficult times; one ASHA served, on an average, 1898 people (Table 5.1).

Table 5.1: Average population and average number of villages catered to by health workers during the phase 1 lockdown

Health workers	Average no. of villages under purview	Average population covered
ANM (N=18)	5.2	8020.3
ASHA (N=138)	2.2	1897.5

Source: Pratichi primary survey 2020

Disruption of Essential Services, Expansion of COVID Duties

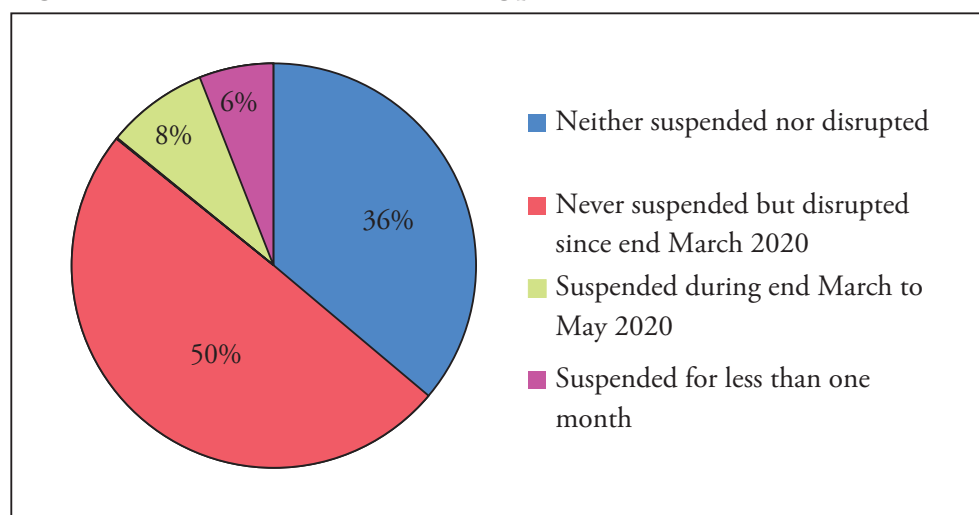
Across the world, the novel corona virus pandemic and the consequent lockdowns have disrupted a plethora of essential services including the essential health services for children. WHO and UNICEF have estimated that 80 million children in 68 countries are at risk of contracting diphtheria, polio and measles owing to the disruption of national immunisation programmes (WHO, No date). In our survey, we intended to map whether routine work of the frontline health workers was disrupted, as disruption of the services like child immunization has a wider ramification for children and pregnant women. A reputed news portal tracked the story of interrupted immunization services during the first wave of the COVID pandemic. The report, based on a national level survey commissioned by CRY, noted “A whopping 63 percent of the surveyed households in the northern states reported the lack of access to immunisation services, followed by West with 39 percent; while less than a third of the respondents reported inaccessibility to immunisation from other regions” (Child Rights and You (CRY) 2020). Our

study also resonates with these findings, as gleaned from the responses of frontline health workers. In the initial days of the national lockdown, our survey found that in 50 percent of cases (Figure 5.1) sub centre services were disrupted during the lockdown. In 52 cases out of 158 (32.9 percent of the sub-centres under review) there was disruption of maternal care services (Table 5.2) and 99 of the said sub-centres (62.7 percent) discontinued their vaccination services (Table 5.3).

A Ministry of Health and Family Welfare guideline titled 'Immunisation Services during and post COVID-19 outbreak' stipulated that “No active mobilization to the health facility be carried out”. However, the same document says that “Every opportunity is to be utilized for vaccinating beneficiaries if they have already reported at the facilities” (Ministry of Health and Family Welfare, No date¹). This had led to some confusion among the frontline health workers about whether they should continue or stop these services.

We have found disruption of immunization services in the initial months of lockdown in West Bengal too. The frontline health workers have confirmed that services were temporarily withdrawn in their respective field areas.

Figure 5.1: Services of sub-centres during phase 1 lockdown



Source: Pratichi primary survey 2020

As suggested before, 36 percent of the health workers stated that services were neither suspended nor discontinued.

To reiterate once again, the services were disrupted owing to issuance of official

notifications to that effect. As per these notifications, the Government of West Bengal discontinued several of the routine activities of the frontline health workers for a couple of months in the initial phase.

Our primary survey finds that services at about 8 percent of the sub-centres were suspended from March to May 2020. The data also indicates that 50 percent of the sub-centres in question were functional with limited services.

As there was a severe restriction on travel, even the supply of vaccines was irregular for the initial months, and beneficiaries couldn't visit the centre because of the same reasons. Parental hesitation to visit health centres in a climate of overall panic also added to this faltering functioning of the centres. In addition, a host of standard outreach activities of the frontline health workers were suspended to divert their energies and efforts to focus on tracking and surveillance of returnee migrants. Encouragingly, however, the study team found that despite some disruption in the activities of the sub-centres, ASHA workers still carried out a number of essential services pertaining to reproductive and child healthcare. They provided door to door service which included home deliveries and were in regular contact over the phone with the mothers and would-be mothers.

Maternal care support is one of the key services provided at the sub-centre. A sizeable section of expecting women in rural areas largely depends on the sub-centre for a wide variety of services including registration, examination, counselling.²

²For details of the services, see Ministry of Health and Family Welfare (No date).

Table 5.2: Maternal care during the national lockdown (end March to May 2020)

District	Number of sub-centres	Not provided	Provided
Bankura	2	0	2
Birbhum	17	8	9
Cooch Behar	16	5	11
Dakshin Dinajpur	4	0	4
Hooghly	12	2	10
Howrah	12	4	8
Jalpaiguri	16	6	10
Murshidabad	18	4	14
Nadia	14	6	8
North 24 Parganas	16	5	11
Purba Bardhaman	4	1	3
Purulia	12	3	9
South 24 Parganas	15	8	7
Total cases	158	52	106

Source: Pratichi primary survey 2020

Our study found that during the period between end March and May 2020, maternal care was suspended in about 32.9 percent of sub-centres, primarily because ASHA workers were engaged in a host of other COVID prevention activities like contact tracing, surveillance etc. It needs underlining, therefore, that there was no lockdown for this workforce, and no respite from, and only proliferation of, their arduous load of work.

As an aside, it may be mentioned that health workers could anticipate the consequences of the disruption of immunization services. That delayed immunisation could put children at the risk of being infected with diseases that could in turn contribute to a rise in child mortality rate was also apprehended by the health workers. Some online news reports found that health experts and other health service providers could foresee the challenges ahead.³

³ As Bagchi (2020) reported, “In India, interviews with parents, health workers, government officers and public health experts in West Bengal, Delhi, Bihar, Uttar Pradesh, reveal that the COVID-related disruptions to the country's immunisation and vaccination programmes has created a real risk of a measles outbreak – suggesting a nightmare scenario of overburdened public health systems trying to cope with simultaneous outbreaks of measles and COVID-19”.

Table 5.3: Immunization during the national lockdown (end of March to May 2020)

District	Number of sub-centres	Not provided	Provided
Bankura	2	0	2
Birbhum	17	15	2
Cooch Behar	16	9	7
Dakshin Dinajpur	4	2	2
Hooghly	12	7	5
Howrah	12	6	6
Jalpaiguri	16	11	5
Murshidabad	18	9	9
Nadia	14	9	5
North 24 Parganas	16	12	4
Purba Bardhaman	4	3	1
Purulia	12	5	7
South 24 Parganas	15	11	4
Total cases	158	99	59

Source: Pratichi primary survey 2020

Long Working Hours

On paper, ASHA workers are supposed to work for 3-4 hours per day. We have found out from our interaction with them that during normal times they work on an average for 7-8 hours. This got amplified by a big margin during the crisis time. A study in 10 States (Behan Box Report) also found that “As a result of the increased pandemic duties, ASHA workers have, on an average, had to work in the field for 8 – 14 hours every day including weekends” (BEHANBOX 2021).

As indicated previously, some of the routine activities were temporarily suspended during the initial days of lockdown, yet the involvement of ASHA and ANM workers in the field was significantly expanded. During the long stretch of the lockdown, our study found that the working hours of ASHAs extended to 13 hrs.

Despite severe disruptions of public transport, almost 93 percent of ASHA workers could conduct their home visits during the period under review. It is well to point out that in our study there is significant difference between the answers of the household respondents and those from service providers in this respect.

Table 5.4: Home Visits by ASHA workers during the national lockdown (in percent)

	Did not make house visits	Visited households	Other*
ASHA (N=140)	5.0	92.9	2.1

Source: Pratichi primary survey 2020

*Other- they themselves contacted COVID-19 at that time

To quote Shefali Saha⁴, an ANM worker from South 24 Parganas, “Before Corona, we had a routine of work and family life. I used to work for 7 to 10 hours and still had time to spend with my family, friends and colleagues. I could visit my relatives at different places during weekends. I used to have leisure time. But now the pandemic has disrupted both my work and private life. Now I'm working round the clock without any leave. There are times when I get a call at midnight and have to rush to work. The higher authorities have told us to keep our phones switched on at all times and be prepared for any emergency. Our posting could be anywhere. We do not know when our lives will return to normal.”

Her narrative is not an exception; other studies and newspaper reports confirm similar accounts about their long hours of work.

For almost a year, both ANM and ASHA workers have practically had no leaves or holidays. They have been working relentlessly without any break. As a result, it has taken a toll on their personal life. Domestic work at home has not necessarily reduced, but owing to the excessive workload they can't give time to their children or look after them.

Turning to their official responsibilities, due to the unavailability of proper transport, hospitalisation of patients was hampered in a number of cases. It was reported that hospitals on several occasions were refusing to admit pregnant women. Even in such bleak times, ASHA workers could ensure 96.7 percent institutionalised deliveries (1176 out of 1216) from end-March to May 2020 (Table 5.5). This figure appears to be higher than what is recorded in NFHS-5 (2019-2020). According to the NFHS, the corresponding figure of institutional delivery in West Bengal is 91.7 percent (International Institute for Population Science and Ministry of Health and Family Welfare, No date).

⁴All are pseudonyms.

Furthermore, a door-to-door survey by ASHA workers on the extent of co-morbidities in rural areas was conducted across the state; similar work was done in urban areas by health workers. The exercise was useful in identifying the most vulnerable people; such real-time data collected by these so-called voluntary workers helped significantly in reducing the mortality rates.

Table 5.5: Delivery during the national lockdown

District	Expected delivery	Institutional deliveries	Home deliveries
Bankura	7	7	0
Birbhum	148	145	3
Cooch Behar	96	92	4
Dakshin Dinajpur	9	9	0
Hooghly	47	47	0
Howrah	71	66	5
Jalpaiguri	92	89	3
Murshidabad	125	125	0
Nadia	270	249	21
North 24 Parganas	75	71	4
Purba Bardhaman	37	37	0
Purulia	68	68	0
South 24 Parganas	171	171	0
Total	1216	1176	40

Source: Pratichi primary survey 2020

During the first week of June 2021, as essential health services started re-opening, the burden of work became onerous for ASHAs and ANMs, as they had to make up for the huge backlog in immunization created in the preceding three months of lockdown. They had to resume and even boost up full vaccination drives and out-reach programmes which were halted due to the lockdown.

Next we turn to discuss how far they were equipped and protected in tune with their enlarged set of duties.

Protective Gears for ASHA Workers during the Lockdown

According to the guideline issued by the Ministry of Health and Family welfare, ASHAs and ANMs were mandated to execute the following work: contact tracing,

surveillance of the community and awareness building on COVID protocol (Mission Director (NHM) 2020). Of particular importance was the role they were supposed to play in building community level awareness on using masks, and hand sanitizers, and maintaining 'social' distance etc. We found through our interaction with some of them that there had been a dire shortage of Personal Protective Equipment (PPE) during the initial phase of the pandemic. A national level study also found that “only 75 percent ASHA workers were provided with masks, and only 62 per cent received gloves to perform their duties. This is despite the evidence that use of masks reduces the transmission rate of Corona virus infection” (Raini 2020).

No doubt, the norms for basic safety equipments for frontline health workers were prescribed by various authorities. These included provisioning of PPE kits, masks, hand sanitizers, hand gloves, washing soap, disinfectant agent, caps etc. The study team observed that the level of protection for ASHA workers was set lower to that applicable for other health care workers. After the first few months, the respondents in the survey stated, hand-sanitizers and masks were available, but inadequate as compared to their requirement. The health workers reported that only 43.7 percent had an adequate supply of masks (Table 5.6), 32.3 percent of gloves (Table 5.7), 44.9 percent of hand sanitizers (Table 5.8), 20.9 of disinfectant agents (Table 5.9), and supplied on time. It clearly shows the high level of risk that the frontline workers were exposed to while serving the people against the deadly virus, at least in the initial months.

Table 5.6: Supply of face masks

Supply of face masks	All	ANM	ASHA
Initially not supplied	35 (22.2)	2	33
Never supplied	1 (0.6)	0	1
Never supplied adequately	50 (31.6)	6	44
Other	3 (1.9)	0	3
Supply adequate	69 (43.7)	10	59
Total	158 (100.0)	18	140

(Figures in parenthesis indicate the percentage)

Source: Pratichi primary survey 2020

Table 5.7: Supply of hand gloves

Supply of hand gloves	All	ANM	ASHA
Initially not supplied	24 (15.2)	2	22
Never supplied	31 (19.6)	1	30
Never supplied adequately	48 (30.4)	6	42
Other	4 (2.5)	1	3
Supply adequate	51 (32.3)	8	43
Total	158 (100.0)	18	140

(Figures in parenthesis indicate the percentage)

Source: Pratichi primary survey 2020

Table 5.8: Supply of sanitizers

Supply of hand gloves	All	ANM	ASHA
Initially not supplied	26 (16.5)	3	23
Never supplied	3 (1.9)	0	3
Never supplied adequately	52 (32.9)	3	49
Other	6 (3.8)	0	6
Supply adequate	71 (44.9)	12	59
Total	158 (100.0)	18	140

(Figures in parenthesis indicate the percentage)

Source: Pratichi primary survey 2020

Table 5.9: Supply of disinfecting agents

Supply of hand gloves	All	ANM	ASHA
Initially not supplied	16 (10.1)	2	14
Never supplied	93 (58.9)	10	83
Never supplied adequately	14 (8.9)	0	14
Other	2 (1.3)	0	2
Supply adequate	33 (20.9)	6	27
Total	158 (100.0)	18	140

(Figures in parenthesis indicate the percentage)

Source: Pratichi primary survey 2020

Commenting on their lack of protection against the Corona contagion an ASHA worker from Jalpaiguri said, “We were forced to use normal thermometers because the authorities did not provide us with thermal guns to check the body temperature of the people.” The health workers, on many occasions, were forced to buy health protection equipments as the supply hardly reached them on time.

In our survey it was seen that 55.7 percent health workers self-purchased these items (Table 5.10). In some cases, help was received from a few NGOs and villagers in this respect.

Table 5.10: Health workers who purchased protection equipment ever

Self-purchased health equipment ever	All	ANM	ASHA
Did not purchase	70 (44.3)	9	61
Purchased	88 (55.7)	9	79
Total	158 (100.0)	18	140

(Figures in parenthesis indicate the percentage)

Source: Pratichi primary survey 2020

“My duty was to collect swab from migrant workers, but I was provided with only one PPE kit. Though the kit was for single use, I was forced to wash it regularly after returning home”, said Rina Mitra, an ASHA worker from Howrah District.

Training on Curbing the Spread of Virus

On March 27, 2020, the Ministry of Health and Family Welfare released a notification suggesting proper training for frontline health workers on the basic management of COVID outbreak (Mission Director (NHM) 2020_a). And all health workers were envisaged to get such training. In our study, we have found that 14 out of 18 ANM workers received this training, whereas only 61 out of 140 (43.6%) ASHA workers did so (Table 5.11).

To quote the Behan Box report in this context, “ASHA workers in many states mentioned that they were deputed to field duties without any training whatsoever. They picked up information on safety protocols from sources such as radio and television” (BEHANBOX 2021).

ASHA workers are trained to work as frontline line health workers mainly as members of a community outreach programme, yet they were deployed to practically step into the shoes of public health staff in position in the temporary quarantine centres set up for the migrant labourers.

Their core responsibilities at those centres were to record the body temperature of the returnees and their address; and if any COVID symptoms among the

migrants were identified by them, ASHAs would refer them for a COVID Test. These frontline workers were sent to containment zones without any proper training, thus putting their lives at risk. We have come across a few cases in which ASHA members got infected with COVID, upon their return from these temporary quarantine centres.

Table 5.11: Health workers and their COVID-19 related training

Health workers	Received training	Did not receive any Training	Total cases
ANM	14	4	18
ASHA	61	79	140

Source: Pratichi primary survey 2020

In the hierarchical structure of the health system, those at the bottom of the graded edifice, namely the ASHA workers, experienced training deficit to a comparatively greater extent, although encountering frontline victims from the most proximate distance.

Hard Work and Inadequate Payment

ASHA workers do not have any fixed monthly salary. Their wage is calculated on the basis of various incentives that remain tied to, and contingent upon, their performance. There are in total 38 different incentives in place for this workforce. These range from Rupees 10 to 1000 and have district-wise variations. All this taken together, at the end of the month in the normal times they used to receive about Rs 4000 to 5000.

Being part of a voluntary workforce, as they are not brought under the purview of certain rights and entitlements that are available under various labour laws, they do not get any paid leave or insurance coverage or social security benefits etc. To make matters worse, in the early days of the lockdown their income fell because the incentive-based services were suspended in several health centers.

During the pandemic, the Central Government announced a monthly payment of Rs 1000 to the frontline workers for their COVID-19 related duties. This expenditure was stated to be shared by both the Central and State Government equally (Mission Director (NHM) 2020). In our study, we observed that the

reimbursement of this amount was very irregular. While only 67 (47.9%) ASHA workers (Table 5.12) received this additional benefit for a period of six months, 3 of them from our study group were yet to receive it.

Table 5.12: Special incentives for ASHA workers

Special incentive	Number of ASHA workers
Did not get any special incentive	3 (2.1)
Received	
For one month	5 (3.6)
For two months	2 (1.4)
For three months	44 (31.4)
For four months	5 (3.6)
For five months	8 (5.7)
For six months	67 (47.9)
For seven months	1 (0.7)
received incentives but did not want to share details	5 (3.6)
Total	140 (100)

(Figures in parenthesis indicate the percentage)

Source: Pratichi primary survey 2020

Turning from incentives to insurance, we may recall that at the end of March 2020, the Union Government announced health insurance coverage amounting to a total of Rs50 lakhs for all frontline health workers including ASHA workers, under the Pradhan Mantri Garib Kalyan Yojana.⁵ In our survey we found that very few health workers were aware of such a scheme. And a handful of those who did hear about it were not in the know of how to lay a claim on this promised entitlement when required, as no follow-up paper work was done. The hard reality of hard work and low pay that characterized the lives of ASHA workers found resonance in the words of Karuna Sil, an ASHA worker from Birbhum, who said “I work tirelessly every day without any leave or break, yet I do not get paid enough. With the incentives that I receive it is very difficult to sustain a family.” Similarly, an ASHA worker from Nadia, Nibedita Halder stated “We ASHA workers are always working at high risk, but we get less than even a daily wage labourer.”

⁵To know the details of Pradhan Mantri Garib Kalyan Yojana, see GoI (No date).

Harassment at Worksites

During the pandemic frontline workers were on the field for many hours struggling to curb the spread of the deadly virus. Their long hours at various worksites created a special kind of vulnerability for them in the form of multiple types of harassment. As far as their regular assignment goes, the ASHA workers mostly remain rooted in the same village, and hence over the years they develop a cordial relation with the members of the households they visit, especially with their female members. During the present crisis however many of them faced ill-treatment, bordering at times on harassment, from the community, primarily due to an apprehension they could be the carriers of the deadly virus, as they were visiting each and every household as part of their official duty. A national level study also raises a similar concern, “ASHA workers we surveyed, mentioned that they have been suspected and vilified for being carriers of the COVID-19 infection themselves” (as quoted in Raini 2020).

On the other side of the register, ASHA workers were facing problems from their higher authorities, as also from the villagers and even from their own family. Higher authorities from the line departments and general administration often gave instructions over the phone sitting at home, sending uncoordinated, confusing and even contradictory messages to these grassroots workers, adding to their already piled up load of harassment.

In our survey, 36 percent (57 out of 158) of the health workers reported having been ill-treated at work and harassed while carrying out their COVID-19 related duties.

Table 5.13: Health workers faced harassment while discharging COVID duty

Health Workers	Did not face harassment	Faced harassment	Total
ANM	11	7	18
ASHA	90	50	140
All	101	57	158

Source: Pratichi primary survey 2020

Table 5.14: Health workers faced harassment while discharging COVID duty (social category wise)

Social category of Health workers	Did not face harassment	Faced harassment	Total health workers
General	42 (63.6)	24 (36.4)	66
OBC	14 (51.9)	13 (48.1)	27
SC	37 (67.3)	18 (32.7)	55
ST	8 (80.0)	2 (20.0)	10
All	101 (63.9)	57 (36.1)	158

(Figures in parenthesis indicate the percentage)

Source: Pratichi primary survey 2020

“Leave, if you can't work under pressure,” were the terse and harsh words that Lakshmi Sarkar, an ASHA worker from Howrah, received from her higher authorities, when she found it difficult at times to submit her reports on time, reeling under extreme pressure of field work. They were also reprimanded sternly if errors were found in their reports that were not uncommon after the daily grueling sessions of their COVID duty. Working in villages threw up another set of challenges for them. They were targeted by villagers and abused simply because they were carrying out their duties. Sufia Begam, an ASHA worker from Murshidabad, said, “I advised them not to go out since there was a lockdown. But people were frustrated as they did not have any source of income. Going out to look for a job was their only option. Put in this stalemate position, they showered me with abuses whenever I went to work in those areas.”

One ASHA worker broke down while sharing her experience with us. She was threatened with dire consequences by liquor selling goons in her area of work if she were to continue working there. Even after receiving such threats, she could not take legal recourse as she would have to work with the same people afterwards.

Their interactions with migrant workers were also fraught with tales of helplessness and challenge, as one set of vulnerable people encountered another section of frontline victims. Migrants showed all their anger towards ASHA workers, owing to mismanagement at the quarantine centres, on which the latter hardly had any control. As one ASHA worker recollects “when the migrants were protesting against not being allowed to go home despite being so close to it and

when having no symptoms of fever, we tried to convince them that it was absolutely mandatory for all returnees. They became impatient and tried to break the barricade. The police stationed over there were watching from a distance. The panic level was so high that they did not get close to the returnees. But we were forced to manage the centre for three days at a stretch. Who would ensure our security? Most of the inmates were aged between 16 and 40 years and males and we were only three ASHA workers. Even basic water and sanitation facilities were inadequate”.

What compounded their woes were the age old and deep rooted gendered and patriarchal norms in our society. Many ASHA workers complained that they were not taken seriously and were made fun of simply because they were women. 'Women do not know anything. Why should we listen to them?' was not an unexpected refrain. Gendered norms at times worked unfavourably even within their own family. After returning from their daily 'volunteer' work, it was not easy to find peace at home. They sometimes faced isolation at home and were not allowed to sleep on bed or inside the house. Hence, they were forced to sleep on the floor or out in the verandah.

A Public-spirited Workforce

Against the backdrop of all this hardship, one question sprang up naturally why did they still continue to work under such circumstances that were fraught with disrespect? What motivated them to carry on against all odds? With their qualities they could have got a better paid job, and yet they chose to be an ASHA member. The government considers them as mere 'volunteers'. But they choose to work and have chosen to work with full dedication in this crisis time. Being an ASHA worker helped them perceive the value of life differently. In our study it was seen that 70.7 percent of health workers considered this as their 'duty' and not as just volunteer work (Table 5.15). Trisha Barman, an ASHA worker from Cooch Behar said, “During my training days I was informed that I will have to carry out my duty under any circumstances. I was advised not to leave my work if there arose any unpleasant situation.” Many workers like Trisha have carried out their work irrespective of the arduous situation they have found themselves in.

More than three-fourth (78.7%) of the health workers (ASHAs and ANMs) revealed that they did their work because they loved the people they worked with (Table 5.15). While working, the women in the village became their close friends. Hence, they were still working hard in this pandemic to lend support to the villagers. ASHA workers were determined to continue their work because they loved the people as well as their job. During the initial days of the pandemic, the ASHA workers were anxious and nervous vis-a-vis the situation under which they were supposed to work.

Table 5.15: Factors that motivate health workers

Health Workers	Support from others (colleagues, villagers, family)	Try to help others	For duty	For money	For later benefits	Love to work	Number of cases
1st and 2nd ANM	6 (37.5)	15 (93.8)	16 (100.0)	0 (0.0)	0 (0.0)	2 (12.5)	16
ASHA	29 (21.6)	103 (76.9)	90 (67.2)	40 (29.9)	1 (0.7)	134 (100.0)	134
All	35 (23.3)	118 (78.7)	106 (70.7)	40 (26.7)	1 (0.7)	136 (90.7)	150

(Figures in parenthesis indicate the percentage) (Responses are not mutually exclusive)

Source: Pratichi primary survey 2020

But the support they got from their fellow workers, their seniors, ANMs and BMOH supervisors, their family members and villagers helped them overcome this fear and inspired them to work relentlessly to fight the pandemic. More than one-fifth (23.3%) of the health workers said that they got mental and emotional support from their colleagues, villagers and their family. Table 5.15 reflects the multiple motivations of the frontline health workers. However, 26.7 percent of them stated that money, though meagre, was a driving factor behind their decision to work. In the words of Lipi Biswas, an ASHA worker from North 24 Parganas, “I’m the only earning member in my family. My two daughters are still studying. So the incentive I receive, however small, is very dear to me.” There are many like her who may not have openly discussed their financial hardship with us, but are in a similar situation and hence consider this little money they earn as precious for their subsistence and sustenance.

Concluding Remarks

ASHA workers have significantly contributed toward improving child and maternal health indicators, stabilizing birth rates and creating awareness about health and hygiene. According to health statistics, the child mortality rate was 57 per 1000 live birth in 2006 and reduced to 33 per 1000 live birth in 2017.⁶ Institutional delivery has significantly improved across the Indian States. About 14 States have registered over 90 percent of birth under institutional care (Ministry of Statistics and Programme Implementation, No date). Frontline health workers, especially ASHAs and ANMs have played a pivotal role in improving the health indicators, yet they remain highly 'invisible in the policy discourse. There has been some sporadic protest against their low wage and long duty hours, still these problems have been routinely overlooked. Even internet search on ASHA workers used to yield little results prior to the Pandemic. If it wasn't for the pandemic, the value and contribution of the ASHA workers would have remained largely unnoticed. Both in the governmental circle and among the public at large there is an urgent need to recognize that they are the street-level backbone of the health care system that is embedded in turn in a largely rural setting. We can improve our rural health system if we properly use the power of ASHA workers at the ground level. On being asked how the condition of the frontline could be improved, their response not only includes better wages but also dignity, recognition and respect, better training to deal with health emergencies, paid leave and social protection.

The COVID induced health emergency clearly exposed the fragility of private health care facilities. The lion's share of the COVID crisis was managed by public institutions and in particular by the frontline women health workers especially in rural areas. This calls for an overhaul of the health system where sufficient budget should be allocated for the promotion and protection of the frontline health workers.

⁶ See for detail, De (2021)

People's Awareness and Action as a 'Social Vaccine'

It was the middle of August 2020. The Corona graph was by then sharply rising towards the peak of its first wave in India. The situation was no doubt alarming. Yet, a self employed, sexagenarian, iron presser, wryly remarked, 'there is no such thing as Corona' (*Corona bole kichhu nei*). Reeling under income losses triggered by the countrywide lockdown, he was training his cynical verbal gun at a top political leader in control of the helm of powers. This political leader who regularly advised the masses to follow the public health norms essential to contain the transmission of COVID-19 failed to quarantine himself after having come into contact with a Corona patient. Unsurprisingly, this sort of gap between the proclamations and practices of the country's top political leadership on many an occasion perhaps gives us a sense of why the routine advisories, for example, for mask wearing and physical distancing have had a low and mixed impact on the people.

It is arguable that state actions and inactions in response to the Corona pandemic have sparked off, quite paradoxically and unhelpfully, the contrasting reactions among the people of panic on the one hand and a cavalier attitude on the other vis-à-vis the COVID-19 disease. On the one hand we find persons like Jiten Paul of Kolkata who neither visited anybody nor allowed any visitors in their house even in the unlock period, persons like Sunil Besra of Bankura Jangalmahal who prayed for relief and protection of common people from the danger of COVID-19; on the other hand we also come across persons like Nazrul Islam, a casual employee of the Indian Postal Service of Murshidabad district, who point out that people are very reluctant to wear face masks¹. Interestingly, although there are criticisms from various quarters about the reluctance among people to wear masks, a majority of the respondents in our survey seemed to be quite aware of the public health norms suggested for protection from the infection. Undoubtedly, as in many other states of India, inadequate health infrastructure in West Bengal, pre-existing socio-economic vulnerabilities of large sections of its population,

¹ All are pseudonyms.

decline in public services in some key areas, and people's behavioural inconsistencies all combined to pose serious challenges to the control and management of both COVID and non-COVID diseases. In the following sections of this chapter, people's knowledge and understanding of this contagion, and their behavioural responses to the same have been documented, with a fleeting glance having paid to their housing and hygiene conditions that certainly shape and limit their behavioural choices. We have also looked at some of the policy responses or their lack in the light of which we need to measure citizens' responses. A fleeting glance has also been paid to healthcare meted out to people for non-COVID diseases during the reference period. Encouragingly, according to our survey, despite many limitations, the health care of the people for non-COVID diseases did not suffer much during the first wave of the COVID-19 outbreak in West Bengal.

Pre-existing Housing and Hygiene Vulnerability as a Challenge against Risk Mitigation

The challenge to respond to the COVID contagion gets aggravated due to the poor housing and hygiene conditions that many people have to live under. The World Health Organization (WHO) in the very beginning of the pandemic advised people to follow norms such mask-wearing, physical distancing, frequent hand washing with soap and keeping patients in isolation. In doing so, the WHO drew lessons from the history of transmission of viruses such as MERS (Middle-East Respiratory Syndrome) and SARS (Severe Acute Respiratory Syndrome).²

However, a host of disabling background circumstances including the lack of basic amenities renders most of these advices untenable for a majority of the people in our country, and West Bengal is no exception in this regard. For example, physical distancing in slum areas of Kolkata where the inhabitants live in a condition of extreme proximity in overcrowded dwellings is elusive (Khatua 2020).³ According to the National Sample Survey (NSS) conducted in 2018,

²For details of initial advices from the WHO, see WHO (2020_a).

³The population density of these slum areas is very high – on an average 60,505 persons per sq km in 2011. See Khatua (2020).

nearly one third of the households (with at least one married couple) in West Bengal did not have a separate room for their married couples which indicates the severity of the problem of overcrowding in the state (National Statistical Office 2019). Kumar (2014) identified that congestion was the highest contributing factor causing housing shortage in India. As one of the worst hit states in India in terms of the availability of space, 34 percent of the rural households and 31 percent of the urban households in West Bengal did not have any separate room for the married couples in 2018. Remarkably, the proportion of households that did not have any separate room for the married couples was 11 and 7 percent only for rural and urban areas respectively in Kerala in 2018 (National Statistical Office 2019). As per our survey, 33 percent of the sample households in West Bengal had only one room to sleep in for all the household members, indicating the huge challenge to follow public health measures of physical distancing or self-quarantine/isolation. The severity of congestion problem was higher in urban areas than in rural locations (see Table 6.1a).

Table 6.1a: Rural-Urban distribution of households by the number of living rooms (in percent)

	One room	Two rooms	Three rooms	Four rooms	Five or more rooms	Total*
Rural	29.0 (97)	41.8 (140)	16.7 (56)	8.4 (28)	4.2 (14)	100.0 (335)
Urban	40.9 (67)	34.8 (57)	14.6 (24)	7.3 (12)	2.4 (4)	100.0 (164)
All	32.9 (164)	39.5 (197)	16.0 (80)	8.0 (40)	3.6 (18)	100.0 (499)

(Figures in parenthesis indicate the absolute numbers)

Source: Pratichi primary survey 2020

* The concept of living room had no meaning for one sample household in Kolkata.

They used to live in open air on the footpath. Hence the total sample size got reduced to 499.

While looking at the ratio of household (HH) members to the number of living rooms, we find that 44 percent households had to accommodate their 3 or more members in one room. SCs were the worst hit in this regard, followed by the STs – 48 percent SC households and 46 percent ST households had to accommodate their 3 or more members in one room. On an average one room was available for every 2.8 members of a household in West Bengal. For the SCs and STs, the corresponding figures were 2.9 and 3.1 respectively (see Table 6.1b).

Table 6.1b: Distribution of households by their social category and by the ratio of HH members to the number of living rooms (in percent)

Social category	Mean ratio	Share of HH (in percent)				Sample size
		Ratio 1 or less	Ratio more than 1 but less than 3	Ratio 3 or more but less than 5	Ratio 5 or more	
SC	2.9	2.8 (4)	49.7 (71)	39.2 (56)	8.4 (12)	100.0 (143)
ST	3.1	5.8 (4)	47.8 (33)	29.0 (20)	17.4 (12)	100.0 (69)
OBC	2.4	8.8 (6)	58.8 (40)	26.5 (18)	5.9 (4)	100.0 (68)
Others*	2.7	9.1 (20)	47.0 (103)	32.9 (72)	11.0 (24)	100.0 (219)
All	2.8	6.8 (34)	49.5 (247)	33.3 (166)	10.4 (52)	100.0 (499)

(Figures in parenthesis indicate the absolute numbers)

Source: Pratichi primary survey 2020

* This group represents members of General castes, and in a few cases those unable to identify their caste affiliation.

Thus overcrowding is a very serious problem in West Bengal that renders a substantial proportion of its people vulnerable even in normal times and pushes them into deeper vulnerability during the COVID crisis.

As for the risk of transmission from fecal matters, although there is little evidence of transmission of SARS-CoV-2 from these sources as yet, the WHO recommends separate toilets or latrines for infected persons for the sake of reducing the risk of COVID-19 transmission (WHO and UNICEF 2020). More importantly, while a toilet is shared by many households, the risk of transmission increases due to poor ventilation of the toilets. The contemporary scientific discourses claiming airborne transmission of SARS-CoV-2 strengthen this argument (Greenhalgh et al 2021). But a considerable proportion of households in West Bengal have no option but to accept this risk of transmission due to unavailability of latrine for their exclusive use. As per NSS, 27 percent of households in West Bengal had to either share latrine with other households or use public/community latrine in 2018. For urban areas, this proportion was even higher 31 percent. No other state had such a high prevalence of shared/public latrines in India in 2018 (National Statistical Office 2019). According to our survey, the proportion of households lacking the facility of exclusive latrine, i.e. those either sharing latrine with other households or using public/community latrine, was 11 percent in West Bengal. As usual, the urban areas were more resource-starved in this regard – 22 percent urban households had shared/public

latrines in our survey (see Table A.1 in Appendix).⁴ Thus the shared/public latrine is a serious cause for concern as far as the risk of transmission of COVID-19 in West Bengal is concerned.

Unavailability of adequate water for washing hands several times a day with soap is another area of concern that constrains people from maintaining the Corona hygiene guidelines. The 76th round of NSS found that 9 percent of rural households and 6 percent of urban households in West Bengal were not getting sufficient drinking water throughout the year from their principal source of water. Combined with the accessibility problem, this inadequacy gets even more acute. As per NSS, only 32 percent of households had the opportunity for exclusive use of drinking water in West Bengal (National Statistical Office 2019). As far as water for household activities is concerned, the 69th round of NSS showed (the 76th round of NSS did not capture this aspect) that the proportion of households not getting water sufficiently throughout the year was 15 and 7 percent for rural and urban areas respectively (National Sample Survey Office 2014). Admittedly, there are many states in India that suffer more than West Bengal from inadequacy problem of water, still it is a matter of concern for a considerable proportion of households in West Bengal. Our survey captured the accessibility issue only in regard to water during data collection. It found that 36 percent of households in West Bengal had the opportunity for exclusive use of drinking water from a principal source. The corresponding figure for other household activities was 48 percent. The majority of households had to arrange for their drinking water from public/community resources in West Bengal (56%) (see Table A.2a and Table A.2b in Appendix). Overall, it may be said that while the problem of insufficiency of water does not appear very serious in West Bengal, for a sizable section of the populace, it is indeed very difficult to follow the WHO advice for frequent hand wash with soap.

Also, hand washing as a practice has not been a prevalent feature among the people in West Bengal even in normal times. As per the 76th round of NSS, only 28 percent of the households in West Bengal had the practice of hand washing before meals with water and soap. The situation was worse in rural areas – only 19 percent of the households were practising hand washing with water and soap before taking meals. West Bengal was better placed in this regard as compared to

⁴ As per our survey, 9 percent of households had no alternative but to openly defecate in West Bengal and all of such households were from rural areas (see Table A.1 in Appendix).

Jharkhand (11%), Bihar (14%), Orissa (15%), Uttar Pradesh (24%) and Tamil Nadu (27%) (National Statistical Office 2019).⁵

Given this substantial housing and hygiene vulnerability in West Bengal, responding to the outbreak of COVID-19 with the so-called responsible practices was clearly not easy. While computing a composite index of vulnerability in various domains of life at the state and district levels in India, Acharya and Porwal (2020) found that in the domain of housing and hygiene, vulnerability was very high for West Bengal – index value of 0.714. Remarkably, the state of Kerala was found to be the least vulnerable state in this regard with an index value of 0.057⁶.

Peoples' Awareness of the Corona Contagion and Their Behavioral Response

As mentioned before, the handling of COVID protocols, more in breaches than in observance, by many state heads and political leaders often spawned a casual approach among the people about complying with the public health norms. In West Bengal, the pre-election political clashes and mobilizations even in the pandemic season set disincentives for the people to wear masks, or maintain physical distancing etc.⁷ However, the rigorous public campaign launched to make the people aware of the disease and of the precautionary measures essential for protection yielded some good results in terms of knowledge creation. We find that 89 percent of the respondents in our survey were aware of two common symptoms of COVID-19 viz. fever and cough. As high as 92 percent knew that fever was a common correlate of this disease.

Notably, 54 percent of respondents were also aware of breathlessness being one of the symptoms of this disease (see Figure 6.1). This proportion was much lower for the survey conducted in Delhi by NCAER National Data Innovation Centre at

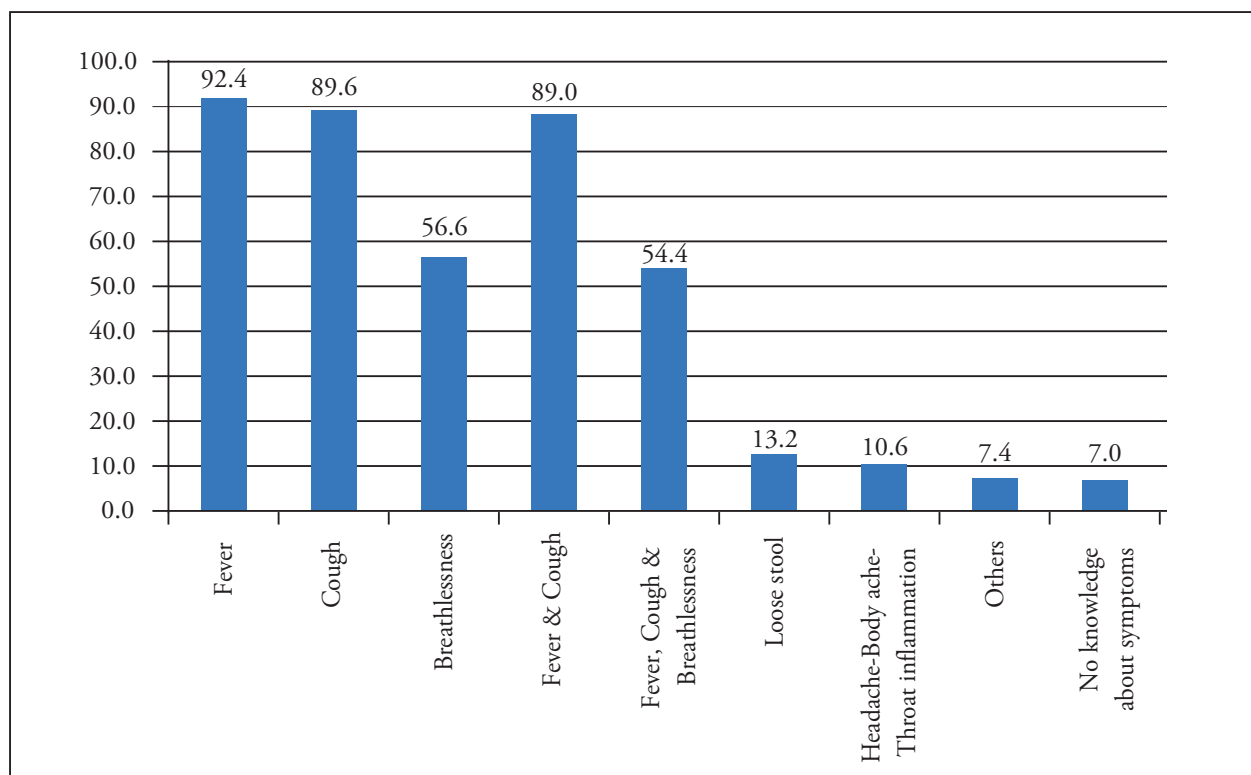
⁵At the all India level, 36 percent of households had the practice of hand washing before meals with water and soap (National Statistical Office 2019).

⁶The vulnerability index for 'housing and hygiene' was based on three indicators viz. 'People per room', 'households with no toilet facility' and 'households with no hand-hygiene facility'. For this exercise, the data was drawn from the National Family Health Survey-4. See Acharya and Porwal (2020) for detail.

⁷Political clashes during the lockdown and political mobilization in the unlock period were common during the first wave.

the beginning of the pandemic – 36 percent of the respondents in their survey had the knowledge of three key symptoms viz. fever, cough and short breath (NCAER National Data Innovation Centre 2020).

Figure 6.1: Respondents' knowledge about symptoms of COVID-19 (in percent)



Source: Pratichi primary survey 2020

However, there was considerable variation among the respondents with respect to the knowledge of symptoms other than fever and cough. For example, their awareness about the symptom of breathlessness which was critical to assess the need for hospitalization was uneven. We find that 50 percent of the rural respondents are unaware of it, while the corresponding figure is 30 percent for the urban respondents. Similarly, while only 5 percent of the respondents in rural areas were aware of the symptom of loose stool, the corresponding figure for the urban areas was 31 percent. Importantly, nine percent of the respondents in rural areas didn't have any knowledge on the symptoms of COVID-19, while it was a meager two per cent for the urban areas (see Table 6.2). Not only was there little difference between females and males regarding the knowledge of symptoms, women were a little ahead of men in this regard, and for every symptom

considered. In case of the associated complication of breathlessness, for example, they were even ahead of their male counterparts by a considerable margin – 61 percent in contrast to 55 percent (see Table 6.2). A part of this difference may however be due to the design and framing of survey questions and their handling over the phone.

Table 6.2: Knowledge about symptoms of COVID-19 by demographic profile of the respondents (in percent)

Symptoms	Rural	Urban	Female	Male	All
Fever	90.1 (302)	97.0 (160)	93.2 (137)	92.1 (325)	92.4 (462)
Cough	87.2 (292)	94.5 (156)	90.5 (133)	89.2 (315)	89.6 (448)
Breathlessness	49.9 (167)	70.3 (116)	60.5 (89)	55.0 (194)	56.6 (283)
Fever & Cough	86.6 (290)	93.9 (155)	90.5 (133)	88.4 (312)	89.0 (445)
Fever, Cough & Breathlessness	48.1 (161)	67.3 (11)	58.5 (86)	52.7 (186)	54.4 (272)
Loose stool	4.5 (15)	30.9 (51)	15.0 (22)	12.5 (44)	13.2 (66)
Headache-Body ache-Throat inflammation	10.1 (34)	11.5 (19)	10.9 (16)	10.5 (37)	10.6 (53)
Others	6.3 (21)	9.7 (16)	8.2 (12)	7.1 (25)	7.4 (37)
No knowledge about symptoms	9.3 (31)	2.4 (4)	6.1 (9)	7.4 (26)	7.0 (35)
Sample size	335	165	147	353	500

(Figures in parenthesis indicate the absolute numbers)

Source: Pratichi primary survey 2020

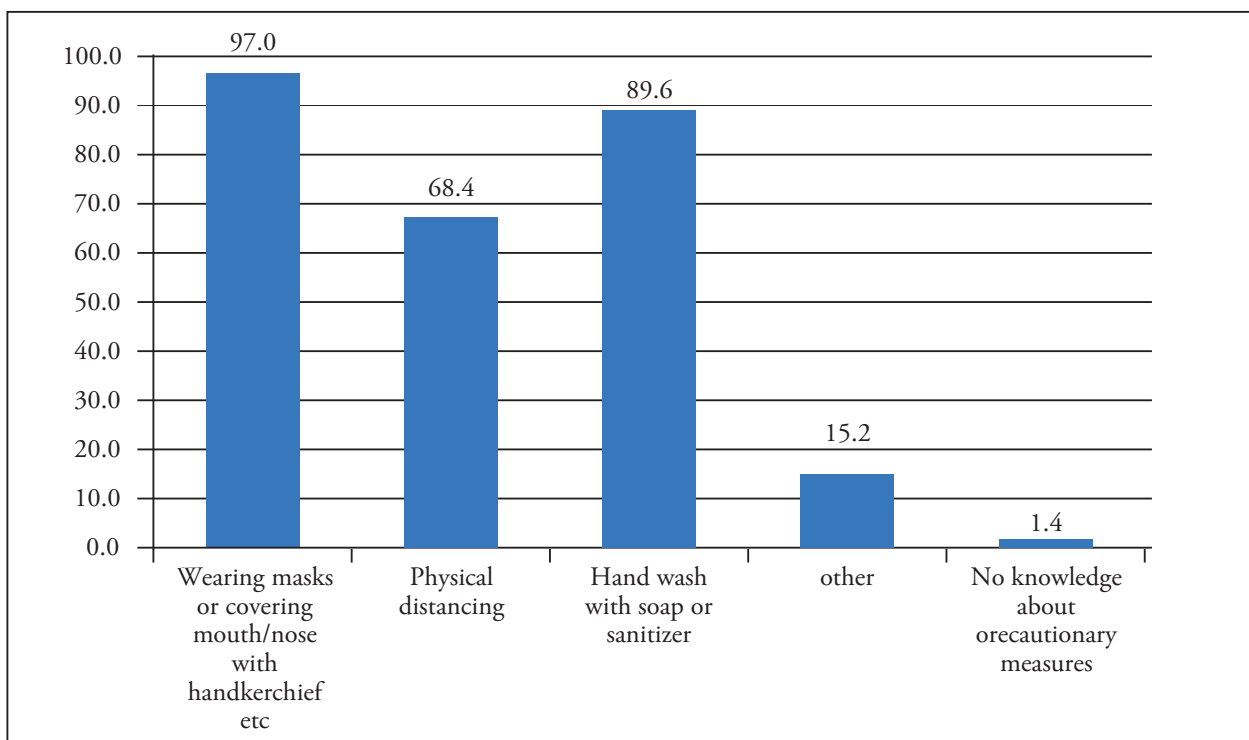
Disaggregating the data on the basis of social category of the respondents, we find that the STs were the least aware of the symptoms of COVID-19 as compared to any other social categories. Not only were one-fifth of the STs found to have no knowledge regarding the symptoms of COVID-19, none of the ST respondents was found aware of the symptom of loose stool (see Table A.3a in Appendix). Thus the dissemination of knowledge regarding COVID-19 was inferred to happen in a lesser extent in the hinterlands which is a matter of grave concern. Importantly, the geographical region of South-West Bengal comprising the districts of Birbhum, Bankura and Purulia, was found, in our survey, to have the lowest degree of popular awareness about the symptoms of COVID-19 when compared with other regions (see Table A.3b in Appendix).

As far as the religious background of the respondents is concerned, significantly, the Muslims were found to be more aware of the symptoms of COVID-19 than the Hindus except for the symptom of loose stool (see Table A.3c in Appendix).

However, as the sample cannot be claimed to be representative of the two communities in question, we refrain from making any definitive claims in this regard. The method of inquiry (without leading questions) may also be an important factor that can partly explain this difference. With respect to the educational level of the households, the level of awareness of the people, not unexpectedly, was found to increase generally with the increase of the households' highest educational level. The respondents having household educational level 'below the primary level' however deviated from this general pattern, though the sample size was not large enough to lay bare this deviation (see Table A.3d in Appendix).

As in the case of knowledge about symptoms, the knowledge of essential public health norms was also found to be an outcome of the public campaigns that were conducted to spread awareness among people about the deadly disease. Most of the respondents in our survey were found to be aware of the critical role of wearing masks (97%) and hand washing with soap or sanitizers (90%).⁸ A sizable majority (68%) was aware of the public health norm of maintaining a physical distance of 3/6 ft (see Figure 6.2). In brief, the three basic public health norms that are thought to be necessary behavioural practices for the people to follow for their own protection from the disease were known to a majority of the people in West Bengal. A negligible proportion of respondents (1%) were unaware of any precautionary measures (see Figure 6.2).

⁸Only a handful of respondents failed to indicate the necessity of wearing masks. It may be due to the framing of survey questions in a manner that disallows leading or directing people to their answers.

Figure 6.2: Knowledge of precautionary measures for protection from COVID-19 (in percent)

Source: Pratichi primary survey 2020

In this regard, the people of rural areas were not much behind their urban counterparts. The differences in knowledge between the rural and urban residents about masks, hand hygiene and physical distancing were 3, 10 and 13 percentage points respectively. Remarkably, none of the urban respondents was completely unaware of the precautionary measures (see Table 6.3). It is important to note that unlike in the case of knowledge about symptoms, women were behind men as far as the knowledge of wearing masks and physical distancing was concerned. Though the difference in case of masks was small (2 percentage points), it was substantial with regard to physical distancing – 10 percentage points. However, in case of hand hygiene, females were ahead of males – 93 percent females as compared to 88 percent males (see Table 6.3).

Table 6.3: Knowledge of precautionary measures for protection against COVID-19 by demographic background of the respondents (in percent)

Measures for protection	Rural	Urban	Female	Male	All
Wearing masks or covering mouth/nose with handkerchief etc	96.1 (322)	98.8 (163)	95.9 (141)	97.5 (344)	97.0 (485)
Physical distancing	64.2 (215)	77.0 (127)	61.2 (90)	71.4 (252)	68.4 (342)
Hand wash with soap or sanitizer	86.3 (289)	96.4 (159)	93.2 (137)	88.1 (311)	89.6 (448)
Others	13.1 (44)	19.4 (32)	23.1 (34)	11.9 (42)	15.2 (76)
No knowledge about precautionary measures	2.1 (7)	0.0 (0)	2.0 (3)	1.1 (4)	1.4 (7)
Sample size	335	165	147	353	500

(Figures in parenthesis indicate the absolute numbers)

Source: Pratichi primary survey 2020

Disaggregating the data on the basis of social category of the respondents, we find that a significant proportion of STs were unacquainted with the basic public health norms. They were particularly uninformed about the necessity of hand hygiene, falling much behind of all other social categories in this respect. While more than 90 percent of the respondents of all other social categories were aware of hand washing with soap or sanitizers, the corresponding proportion for the STs was 64 percent (see Table A.4a in Appendix). Thus STs were found to be the most vulnerable group in the state in terms their knowledge and awareness about effective protective measures against the COVID contagion. The Muslims were better acquainted than the Hindus with these public health protocols (see Table A.4b in Appendix).

As far as the educational background of the households is concerned, the knowledge of public health norms was found to increase generally with the increase of the households' highest educational level. However, in regard to the norm of physical distancing, no general pattern was evident with respect to the educational level of the household (see Table A.4c in Appendix).

Overall, it may be argued that as a result of vigorous public campaigns launched by the state and other agencies, the people of West Bengal largely became aware of the symptoms of COVID-19 and of the precautionary measures essential for the protection from this disease.⁹ Whether people's behavioural practices measured

⁹ In our neighboring country, Bangladesh, this knowledge was found to be absent among the working class population in the first phase of the pandemic (Begum 2021).

up to their knowledge base was the next question that we probed. However, given the inherent limitations of a telephone survey, it has not been possible for us to observe face-to-face the extent of people's compliance with the various safety norms. Indirect evidence about inconsistent mask-wearing among several sections of the population and their inability or un-enthusiasm to maintain physical distancing cannot be ignored altogether. Arguably, knowledge has not necessarily led to responsible action on the part of the masses, especially given the glaring examples of non-compliant behavior of several political leaders themselves. Of course, the social and other vulnerabilities of the people contributed a lot towards their seeming non-compliance. For example, Rishi Natta, a non-agricultural casual labourer from Alipurduar district informed us that he could not follow the safety norms properly as he had no option but to go out and work; again Bimal Sarkar, a petty worker from Murshidabad district told us that he did not always wear masks as a majority in his locality did the same. It is also true that the urban centric prevalence of the disease (observed in the first wave of the pandemic) led many rural residents to adopt a relatively casual approach to the stated public health norms. As Rabi Hembram of Bankura Jangalmahal said, "There is no report of infection in this locality till now. So there is no reason to fear. (*Ekbane karo hochchhe nai, tai voyer kono karon nai*)"

However, it may not be unreasonable to point out that lukewarm behavioural responses from the people vis-a-vis safety norms, have been an artifact, at least in part, of less than optimal response from the state agencies themselves; steering people in the direction of responsible behavioural practices requires concerted social and governmental action and grassroots networking. The experience of Kerala affirms this logic (Roy and Dave 2020, Thomas Isaac and Sadanandan 2020).

All these issues have had a link with the perception level of the people regarding the risks and dangers associated with this disease as well as the remedial steps needed to be taken to deal with them. Only 18 percent of our respondents saw the problem of institutional quarantine as a consequence of SARS-CoV-2 infection and 37 percent perceived the crisis of isolation from the family to be due to the same reason. Nearly one tenth of the respondents did not have any idea at all regarding the associated problems or dangers of the disease. Only 17 percent could perceive that there might arise some problems in terms of access to hospital care for the treatment of COVID-19 (see Table 6.4a). Although people received knowledge regarding symptoms of COVID-19 or the related precautionary

measures, a majority of them could not fathom its actual gravity. However it is important to note that only a negligible proportion of respondents perceived COVID-19 to be a life threatening disease.

Table 6.4a: Distribution of respondents by their perception of problems/dangers associated with SARS-CoV-2 infection by demographic background of the respondents (in percent)

Perceived problems/dangers	Rural	Urban	Female	Male	All
Human to human transmission	70.7 (237)	80.0 (132)	68.0 (100)	76.2 (269)	73.8 (369)
Institutional quarantine	14.3 (48)	25.5 (42)	18.0 (90)	20.1 (71)	18.0 (90)
Isolation from family	28.4 (95)	53.9 (89)	36.8 (184)	36.3 (128)	36.8 (184)
Crisis in hospital care	14.6 (49)	21.2 (35)	14.3 (21)	17.8 (63)	16.8 (84)
Others	7.8 (26)	9.7 (16)	10.9 (16)	7.4 (26)	8.4 (42)
No idea	13.4 (45)	1.2 (2)	12.2 (18)	8.2 (29)	9.4 (47)
Sample size	335	165	147	353	500

(Figures in parenthesis indicate the absolute numbers)

Source: Pratichi primary survey 2020

Perhaps not unexpectedly, we find that the perceptions were relatively unfocussed and imprecise among the rural people as compared to their urban counterparts, among women as compared to men, among the STs in comparison to other social categories (see Table 6.4a and Table 6.4b).¹⁰ It means that the perception level had a close connection with the social status of the people. Remarkably, we did not find any relationship between peoples' perception levels and the households' educational levels.

Table 6.4b: Distribution of respondents by their perception of problems/dangers associated with SARS-CoV-2 infection by social category of the respondents (in percent)

Perceived problems/dangers	SC	ST	OBC	Others	All
Human to human transmission	74.1 (106)	65.2 (45)	81.2 (56)	74.0 (162)	73.8 (369)
Quarantine	16.1 (23)	5.8 (4)	17.4 (12)	23.3 (51)	18.0 (90)
Isolation from family	29.4 (42)	23.2 (16)	37.7 (26)	45.7 (100)	36.8 (184)
Crisis in hospital care	16.8 (24)	14.5 (10)	17.4 (12)	17.4 (38)	16.8 (84)
Others	9.1 (13)	5.8 (13)	5.8 (4)	9.6 (21)	8.4 (42)
No idea	12.6 (18)	15.9 (11)	5.8 (4)	6.4 (14)	9.4 (47)
Sample size	143	69	69	219	500

(Figures in parenthesis indicate the absolute numbers)

Source: Pratichi primary survey 2020

¹⁰ SCs followed the STs in this regard.

As the population in general had a low level of perception regarding the associated problems or dangers of COVID-19 except for the one regarding danger of transmission, it is not unnatural that the people would not bother much about following the public health norms. Still our survey indicates a promising picture that the people at least felt inclined to project themselves as rule-bound and norm-bound individuals, behaving as socially responsible actors. Only a small proportion of the respondents stated that they were not following the basic norms of wearing masks or hand hygiene despite having knowledge about it – the gap between knowledge and reported practice was 4 percentage points for masks and 5 percentage points for hand wash.¹¹ But this gap was considerably higher for physical distancing – 17 percentage points (see Table 6.5). Actually in case of physical distancing, the gap between knowledge and reported practice was much higher for the urban respondents (see Table 6.3 and Appendix Table A.5), indicating perhaps the difficulty in maintaining distancing protocols in the spatially-starved cities and towns. Importantly, only four percent of the respondents reported in a matter-of-fact way that they were not following any public health measures for the prevention of the disease (see Appendix Table A.5)

Table 6.5: Gap in knowledge and reported practice with respect to three basic public health measures

Measures for protection	Proportion of respondents having knowledge (percent)	Proportion of respondents reportedly practising (percent)	Gap (percentage point)
Wearing masks or covering mouth/nose with handkerchief etc	97.0 (485)	92.8 (464)	4.2
Physical distancing	68.4 (342)	51.6 (258)	16.8
Hand wash with soap or sanitizer	89.6 (448)	84.2 (421)	5.4
No knowledge of /Not following precautionary measures	1.4 (7)	4.0 (20)	-2.6
Sample size	500	500	

(Figures in parenthesis indicate the absolute numbers)

Source: Pratichi primary survey 2020

Thus we find that although the potential for behaving as socially responsible actors was strong among the people in West Bengal, the behavioural practices fell short of it.

¹¹ It is to be noted that 30 percent of the respondents in our survey raised the issue of monetary problem in procuring soap or hand sanitizer.

People's Health-seeking Behaviour during the Lockdown and Post-lockdown Months: Non-COVID Diseases in Focus

Taking a comparative look at inter-state variations in Corona control, the public health response in West Bengal appeared less than optimal at the initial phase of the pandemic.¹³ Also, there were vulnerabilities in the domains of health infrastructure and housing & hygiene; as a result care of non-COVID diseases too seemed to pose a serious challenge. Although there was no designated COVID hospital in West Bengal till March 2020, the number of isolation beds for COVID or suspected COVID patients steadily increased till March 2020. While the number of isolation beds distributed among 26 hospitals across the state was 163 on 11 March 2020 (on the day of the announcement of COVID-19 as a pandemic), it increased to 1317 on 31 March 2020, distributed among 100 hospitals across the state (Health and Family Welfare Department 2020_c and Health and Family Welfare Department 2020_d). Since April 2020, the number of designated COVID hospitals also started to increase slowly. M R Bangur, the District Hospital of South 24 Parganas, was the first hospital in the state that was converted into a dedicated COVID hospital (The Times of India 2020).¹³

Thus either due to the provisioning of isolation beds, designated COVID hospitals, or COVID beds, the likelihood of compromising the treatment of non-COVID diseases became real. The crisis became acute during the countrywide lockdown as reaching the health facility appeared as a major hurdle, let alone receiving treatment. Many private doctors also stopped practising during the lockdown. For example, Riten Majhi of Birbhum district, suffering from a

¹² For example, as an indicator of public health measures of testing and contact tracing, the test positivity rate in West Bengal was found to be 5 percent till the announcement of countrywide lock down while the corresponding figure for Kerala was 3 percent. After one month of the lockdown it increased to 6 percent for West Bengal while it decreased to 2 percent for Kerala. If we observe the number of positive cases against the number of tests done in this period of one month after the lock down, we find a test positivity rate of 6 percent in West Bengal, from a tested sample of 8757. In contrast, out of a scrutinized sample of 17840 in the same period, in Kerala, the test positivity rate was found to be 2 percent. [Calculated from the Daily Bulletins of West Bengal and Kerala. See, Health and Family Welfare Department (2020_a), Health and Family Welfare Department (2020_b), COVID-19 Outbreak Control and Prevention State Cell (2020_b) and COVID-19 Outbreak Control and Prevention State Cell (2020_c)]. To have a comparative picture on Case Fatality Rate (CFR) and Recovery Rate, see Z. Ansari et al (2021).

¹³ The bed capacity of M R Bangur was 625 as on 2015 (State Bureau of the Health Intelligence, No date).

neurological disease used to visit a private doctor in Bardhaman district, who became unavailable during the lockdown. Fortunately, treatment available for non-COVID diseases remained relatively undisturbed in rural areas, as the spread of COVID-19 remained confined to urban areas mainly in the first wave of the pandemic. Even in urban areas the health care services for non-COVID diseases didn't collapse altogether in the first wave, though it was a real possibility. Hence, we find that on balance the people in West Bengal somehow managed to avail treatment for their ailments during lockdown and unlock days in the first wave of COVID-19, though somewhat compromising with the quality of care in some cases.

Looking at the disease profile of the households suffering from any illness (other than confirmed cases of COVID) in the period since the lockdown and preceding the survey, we find that 30 percent of the sample households in our survey went through an episode of some non-COVID disease. Out of the total number of 191 such cases four needed hospitalization, while the rest constituted non-hospitalization cases. Table 6.6 shows the distribution of non-hospitalized cases by type of illness. Looking at the type of illness, we find that were cases of 'minor ailments' that required simple interventions that could in principle be made available at a primary health care unit. Thus even amidst the restriction of movement during lockdown and unlock processes, it was feasible for the people to get treatment from local health facilities (government or private).

Table 6.6: Distribution of non-hospitalized cases by type of illness since the lockdown and till the survey (in percent)

Disease	Frequency	Percent
Fever other than Dengue and Malaria	48	25.7
Cold and cough	40	21.4
Gastritis	14	7.5
Injury	12	6.4
Arthritis	7	3.7
Diabetes	7	3.7
Diarrhea/Dysentery	7	3.7
Oral disease (including dental problems)	7	3.7
Headache / Body ache	5	2.7
High blood pressure	5	2.7
Respiratory diseases	4	2.1
Neurological diseases	3	1.6
Cardiac disease	2	1.1
Optical disease	2	1.1
Gynaecological disease	2	1.1
TB	2	1.1
Malaria	2	1.1
Anaemia	2	1.1
Others	16	8.6
Total	187	100

Source: Pratichi primary survey 2020

Analyzing the treatment seeking behavior of people we find that the proportion of people who visited government facilities i.e. either a Primary Health Centre or a Corporation Health Centre or any Government or Public Hospital for their non-hospitalized illness, was only 19 percent. The difference between rural and urban areas was negligible in this regard (see Table 6.7). However, this figure was much lower than what we find in the National Sample Survey (NSS) of 2017-18. As per NSS, 33 percent of rural out-patient care was sought from government facilities in that year (National Statistical Office 2020). The difficulty in accessing health centres in the absence of proper transport during lockdown periods that has continued till unlock days, might have something to do with fewer footfalls at government centres. For example, Krishna Sarkar, a *Dalit* (SC) women from Murshidabad district having a chronic problem of diabetes and thyroid, could not

visit the hospital at Kolkata for her treatment due to the unavailability of trains. The fear psychosis about COVID-19 might also be a reason for people's hesitancy to visit government facilities. Hence it would not be an exaggeration to say that as an effect of the pandemic and the lockdown, some people in rural areas of West Bengal were unable to receive treatment from government facilities.

Table 6.7: Distribution of non-hospitalized cases of illness by type of facility visited and rural-urban residence (in percent)

Type of facility	Rural	Urban	All
Government or Public facilities (Primary Health Centre / Corporation Health Centre/Govt. Hospital)	18.5 (23)	20.6 (13)	19.3 (36)
Private Allopathic Doctors (Chamber/Clinic or Hospital)	22.6(28)	33.3 (21)	26.2 (49)
Private Homeopathy Doctor	4.0 (5)	1.6 (1)	3.2 (6)
Private Telemedicine	1.6 (2)	6.3 (4)	3.2 (6)
Unqualified Medical Practitioner	29.8 (37)	6.3 (4)	21.9 (41)
Medical Store / Self treatment	14.5 (18)	22.2 (14)	17.1 (32)
Others	2.4 (3)	3.2 (2)	2.7 (5)
No treatment	6.5 (8)	6.3 (4)	6.4 (12)
Total	100.0 (124)	100.0 (63)	100.0 (187)

(Figures in parenthesis indicate the absolute numbers)

Source: Pratichi primary survey 2020

In a large majority of cases involving non-hospitalized treatment, medical care was received from private allopathic doctors. More than one-fourth (26%) of the non-hospitalized cases were found to be treated by the allopathic doctors at their chambers or clinics or hospitals. If we add to it the proportions of 'private telemedicine' and private homeopathic care, it increases to 33 percent (see Table 6.7). Disaggregating the data, we find that there was substantial difference between rural and urban areas in this regard – 28 percent for rural areas against 41 percent for urban areas. But the NSS figures for both rural and urban areas were much higher than the figures that sprang out of our survey. As per NSS, 60 and 77 percent of non-hospitalized cases in rural and urban areas respectively were treated by private allopathic doctors in 2017-18 (National Statistical Office 2020). It is arguable that due to the pandemic-triggered economic hardship, there has been a decline in the extent of people's reliance on the private sector. There were some people in our survey who did not visit any health care facility due to a fear from COVID-19 infection and took medicine on their own or with the advice of the

local medical store, but all of those cases except one were from urban areas. The strong presence of Unqualified Medical Practitioner (UMP)s in rural health care services that has been recorded by a number of studies in the so-called normal times (Kanjilal et al 2007, Sarkar 2017) seems to have gained ground in the pandemic season. As per our survey 30 percent of outpatient care in rural areas was sought from UMPs. One may surmise that as a result of the pandemic, reliance on private doctors in urban areas has been partly replaced by self medication on the part of the people, along with the advice of medical stores resulting in a rise in self medication at the cost of quality treatment.¹⁴ But there is hardly any indication of such changes in rural areas that are already at risk due to their pre-existing reliance on services from UMPs.

Overall, it may be said that as an effect of the pandemic or the lockdown, visiting doctors for consultation or treatment either in public or private sector appears to have declined both in rural and urban areas. The phenomenon of Telemedicine and rise in self medication are indications of this trend. Telemedicine and Self medication together comprised one-fifth of the non-hospitalized cases in West Bengal (see Table 6.7). But the danger primarily lies in the increase of self medication that compromises with the quality of care. Remarkably, the impact of the pandemic or the lockdown-related restrictions was also found in the cases of 'No treatment'.

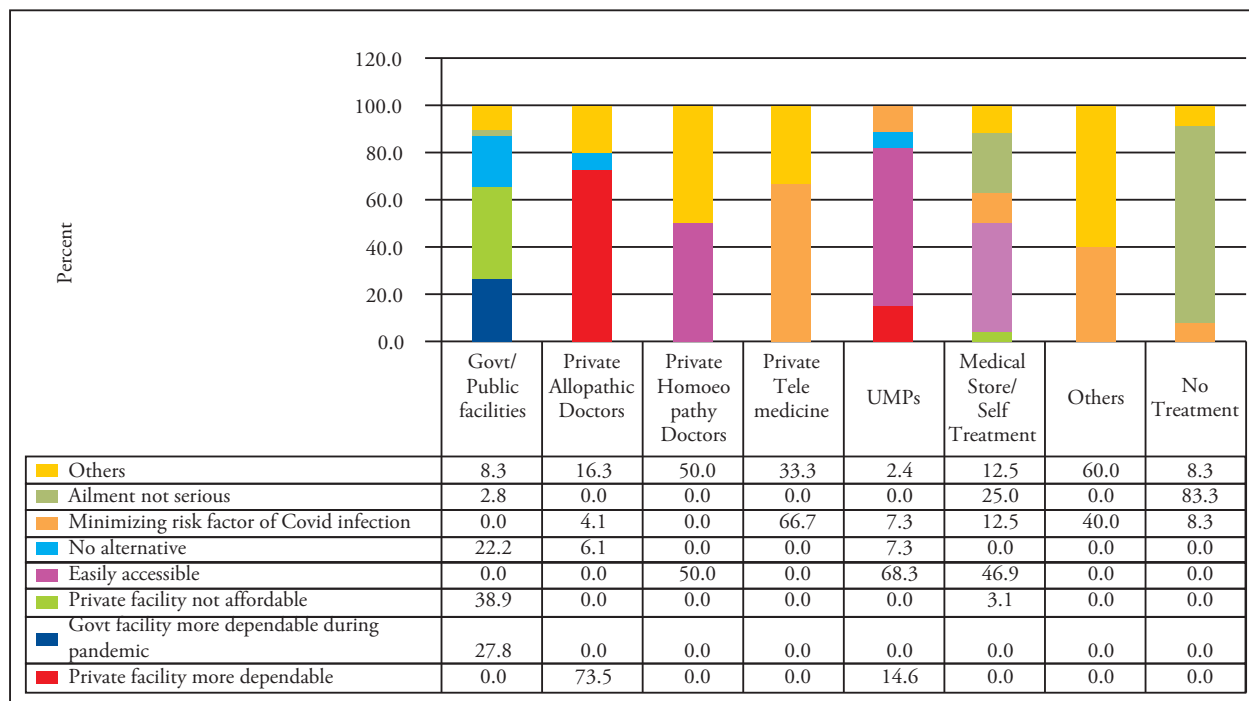
Importantly, we find a variation in the pattern of health seeking behavior of people during the lockdown and the unlock period. While the proportion of people visiting government facilities during the lockdown was higher (33%) than that during the unlock period (17%), the reverse trend was seen for the private allopathic doctors. The proportion of people visiting private allopathic doctors during the lockdown was lower (22%) than that in the unlock period (27%). The trend for UMPs was found to be similar to that for private allopathic doctors – 11 percent during the lockdown against 24 percent during the unlock period (see Appendix Table A.6). There may be multiple factors behind this variation, for example, variation in prevalence of diseases due to seasonal variation, variation in

¹⁴Remarkably the proportion of self medication cases was a little higher (22%) than the proportion visiting government facilities (21%).

operational problems for the private providers during the lockdown etc. But the reported reluctance of private doctors to treat patients during the lockdown might have also contributed to this difference in trend between private and government care. In other words, the private players seem to have largely disappeared from the landscape of medical care at a time when their services could have been critical. However, the under represented sample size for the lockdown period in our survey prevents us from making a very emphatic and definitive claim in this respect.

Looking at the reported motivation of the people for choosing the health facility they chose for out-patient care, we find that majority of those preferring government facility chose it for their inability to afford private allopathic doctors sitting at chambers or clinics or hospitals (39%). But to a substantial proportion (28%), the motive force for preferring government facility was the credibility of the government facility to provide service even during the pandemic (see Figure 6.3). It corroborates with the earlier observation of health seeking behavior of people where care seekers were found visiting government facilities in higher proportion during the lockdown in comparison to the private providers (as discussed above). As far as the private doctors or UMPs are concerned, the received wisdom captured through a number of earlier studies seems to get reproduced: 'Private doctors are more dependable' and 'UMPs are easily accessible' etc. were the common refrain of a majority of those who were seeking care from these private doctors and UMPs respectively (see Figure 6.3). Rather it is important to note that a majority of people preferring telemedicine chose it for minimizing the risk factor of COVID-19 infection. Although the proportion of people preferring self medication for minimizing the risk factor of COVID-19 infection was not high (13%), the phenomenon of avoiding health facilities in fear of infection (even compromising the quality of care) appears to be a significant trend in the first wave of pandemic.

Figure 6.3: Distribution of persons by their reason for choice of health facility and by type of health facility (in percent)



Source: Pratichi primary survey 2020

While looking at the cases of hospitalization, we find that three of the four cases sought treatment from government facilities and one from private facility. This is the usual trend of hospitalization in West Bengal. As per latest NSS survey also, the majority cases of hospitalization was made in government facilities for both rural and urban areas in West Bengal – 74 percent for rural areas and 59 percent for urban areas (National Statistical Office 2020). In our survey, the cases treated at government hospitals were both from rural and urban areas while the sole case of private treatment was from an urban area. But the significant observation in this regard was that the sole case of private inpatient care met with an initial round of admission refusal in the very beginning of the lockdown. In contrast, in one of the three cases treated at a government facility, the person in question preferred the government hospital due to their confidence in government facilities, providing treatment even in the pandemic. Notably, the cases of government inpatient care occurred both in the lockdown and the unlock period.

A Concluding Remark

Scientific knowledge about SARS-CoV-2 is still inadequate to deal with the virus effectively. Inadequate health infrastructure and pre-existing socio-economic vulnerabilities of large sections of its population in West Bengal have added to these shortfalls and correspondingly made the remedial response that much more challenging. However, the signs of the so-called 'social vaccine', i.e., people's knowledge and information about COVID-19 risk mitigation have been encouraging in several parts of the state, although the gap between knowledge and practice remains a cause for concern. People's health seeking behavior for non-COVID diseases, however, reveals a complex picture of intersecting constraints, including those of deficiencies in public health infrastructure, and hesitancy on the part of the people to seek treatment during the pandemic. Nevertheless, on balance, one may contend that although the pandemic or the lockdown compelled some people to compromise with the quality of care or to stop ongoing treatment altogether, the people in West Bengal in general received treatment for their non-COVID diseases despite the presence of grave risks associated with the outbreak of COVID-19. Moreover, it is the public health care service, albeit less-than-ideal, that kept the hope of the people alive for getting a modicum of medical treatment even during the pandemic, as the private players made themselves scarce on many an occasion, leaving the healthcare market dormant and inactive at a time when the need for action was acute.

Care and Un-care of Migrant Workers

The Census of India (2011) showed that more than 14.6 million people migrated for work/employment related reasons (as quoted in Ministry of Housing and Urban Poverty Alleviation 2017). The impact of migration would not be limited to the said 14.6 million only, rather it would be much more than that since often, if not in most cases, the migrants migrate alone leaving their families at home. So, the impact of migration, during that decennial census, might have reached to more than 62 million (considering the average family size of India) population of the country.

The picture of migration may be complex taking into consideration myriad factors such as their skill sets, relation with their employer, their knowledge about destination, social capital formation in the destination, distance from home, condition of employment, duration of stay, and volume of income and so on. For example, those who reached destination immediately before the lockdown might have been in a more vulnerable situation than those who were working there for a long time. This was primarily because the former were likely to have a little cash in hand as compared to the latter.

Global reports (e.g. UNDP 2009, ILO 2021) on migration have recognized migration as an important aspect of development and development policy. This has been reflected in the formulation of targets in the UN 2030 Sustainable Development Agenda. Its target 10.7 advocates an orderly, safe, regular and responsible migration and mobility of people and implementation of planned and well-managed migration policies. The target 8.8 advocates the protection of labour rights and promotion of safe and secure working environments for the workers including migrant workers (United Nations, No date).

The issue of labour migration in India should have been paid serious attention at the time of announcement of the lockdown on March 24, 2020. Instead, it received sheer disregard from the authorities that were prominent in policy

making and their implementation (Anandabazar Patrika 2021). Noticing this neglect and inattention to such a momentous issue the Supreme Court of India issued orders for the governments to pay due attention, particularly with respect to their access to food, accommodation and their travel back home.

Given the diversity and complexity inherent in the phenomenon of migration, it is not unexpected that strategies followed by different groups of migrants and by different categories of concerned stakeholders including government agencies, have been different in response to the situation that emerged after the lockdown. Policy making and their implementation pertaining to migration is contingent upon availability of adequate data particularly with respect to the extent of migration, the socio-economic and demographic profile of migrants, employer-labourer relation in the destination, importance of migration in the life of migrants, contribution of migrants to development in source as well as destination areas etc. But the authorities remained largely silent both with respect to collation and dissemination of such data as well as follow-up action.

Lack of adequate knowledge may lead to improper policy making, as has been demonstrated by a circular issued by the Ministry of Home Affairs. According to this circular, employers in question were instructed by the Ministry to pay wages to their employees during the lockdown period (as quoted in Jayram and Varma 2020). This indicates little understanding on the part of the government about the financial strength of the employers and their relation with their workers. There may be a wide range of employer-worker relationship, in the universe of migration. Let us take the case of masons and their helpers who generally work with no fixed employers, and not for a long stretch. Having finished assignments with one employer, they search for another. Are these employers expected to provide wage to their workers for the lengthy lockdown period? There were some labour contractors, who themselves were migrants. The workers and the actual proprietor of work had no interaction or linkage in some cases. In a situation in which earnings of labour contractors were uncertain, how feasible was it to expect them to pay wage to workers working under them? Or did they have power to claim wages for their workers from their bosses? What about the plight of self employed migrants? They had no employer and therefore, nobody was there to

compensate for their income. Therefore, the implementation of the above circular was perhaps foredoomed to falter.

Against this perilous backdrop, this chapter attempts to contribute to an understanding of the lives of migrant workers returning to West Bengal, after the announcement of the national lockdown, focusing particularly on the nature of challenges they faced and support they received from various stakeholders.

For this purpose, data was collected from 500 migrants spreading in three districts of West Bengal – Malda, Murshidabad and Birbhum - the three districts in the state that are known to be 'origins' of a large number of migrants. The interviews were carried out over telephone during the period between January and April 2021. Most of the telephone numbers were collected from the agencies that recorded them at the point at which returnee migrants reported to the state authorities in 2020.

Brief Background of the Source Area

Historically West Bengal is a recipient as well as supplier of migrant labourers. The industrial belts received a large number of migrant workers from the neighbouring states such as Bihar. The agriculture sector, during the peak seasons, also received migrant workers from Dumka district belonging to the neighbouring state (then Bihar but at present Jharkhand) as well as from some pockets of the state itself (Rogaly 2001).

Pattern of migration has changed over time spreading to the non-agricultural sector in and out of the state. Some districts, such as Malda, Murshidabad and Birbhum, are among the most important sources of migrants. Those districts are among the most backward districts in the state and are among the 250 most backward districts in the country that received support from the Backward Region Grant Fund from the 11th Five Year Plan Period. The backwardness of these districts may be apparent when some development indicators like literacy rate, population pressure on land, urbanization, and industrialization are compared.

Table 7.1: Some basic information on three selected districts (as per Census 2011)

	West Bengal	Malda	Murshidabad	Birbhum
Population	91276115	3988845	7103807	3502404
Share of urban population (%)	31.9	13.6	19.7	12.8
Share of Muslim population (%)	27.01	51.27	66.27	37.06
Literacy rate (%)	76.26	61.73	66.59	70.68
Population density (per sq km)	1028	1069	1334	771

Source: Bureau of Applied Economics and Statistics (2015)

Table 7.1 shows that all three districts fall below the state average in terms of the share of urban population and literacy rate but above the state share in terms of Muslim population, one of the marginalized communities in the country. Due to poor urbanization and industrialisation the people in these districts have poor access to opportunities available in the non-agricultural sector and consequently they are heavily dependent on the already overstretched agricultural sector where the size of landholding as well as return from it is very small. More than 96 percent of the agricultural households have land below one hectare (GoWB, No date), which is inadequate to provide necessary livelihood support to the people. Moreover, according to the Socio Economic Caste Census 2011, 70 percent rural households in West Bengal, as against 56 percent in the country as a whole, do not own any agricultural land (as quoted in Damodaran 2015). The incidence of poverty in all three districts is high. In this context migration has become one of the major livelihood strategies of the people in this area.

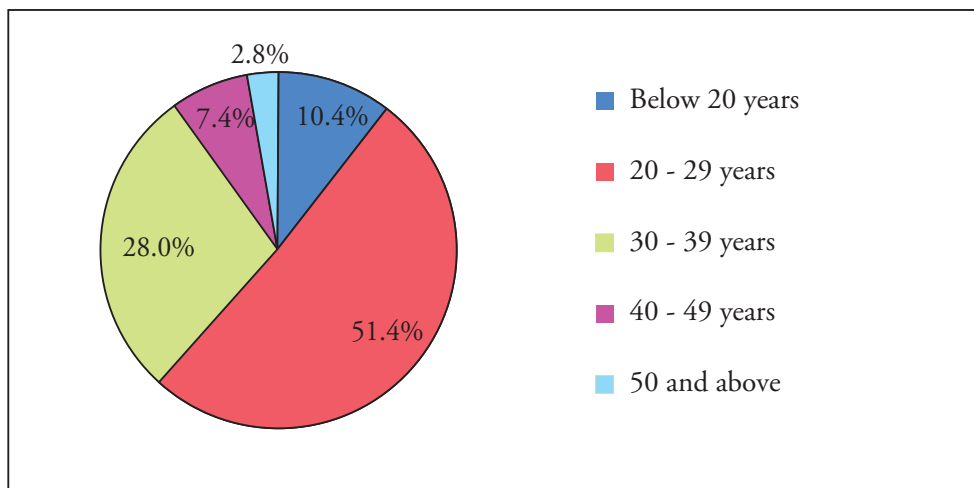
Respondents at a Glance

It has been stated earlier that the interviews were carried out with migrant workers from three districts – Malda, Murshidabad and Birbhum. Out of the 500 respondents, the share of Malda, Birbhum and Murshidabad districts were 44, 42 and 14 percent respectively. Although the phone numbers of the migrants were picked up randomly from the available directory of phone numbers, it was found that the number of respondents remained highly skewed towards male migrants, indicating that the extent of female migration is very low from these districts,

conforming Rogaly et al (2001). The share of female migrants in this study was found to be only 1.4 percent.

Distribution of respondents by age group also shows an interesting picture. Migrants were found to concentrate in a particular age group, majority of them belonging to the age group 20-29 years (51.4%), followed by 30-39 years (28.0%). This also indicates that a large group of people from the said districts spent a large part of their most productive period of life as migrants.

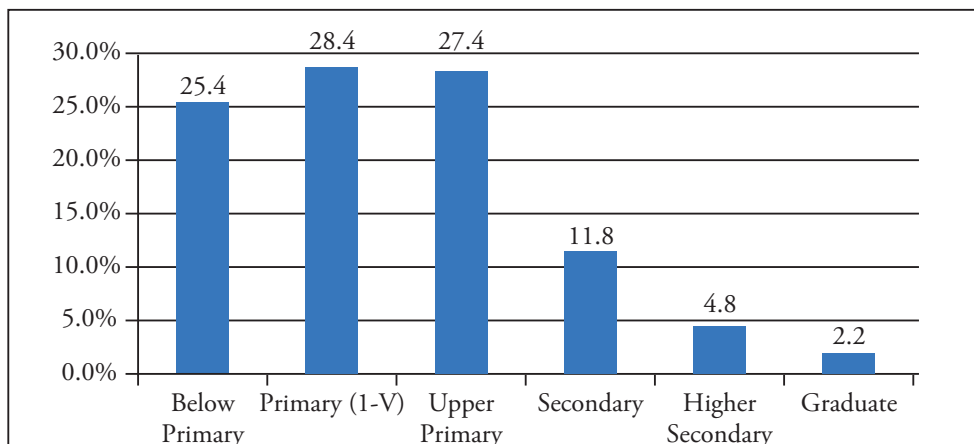
Figure 7.1: Distribution of migrants by age group



Source: Pratichi primary survey 2021

The level of education and the propensity for migration were found to be inversely related. It appears from Figure 7.2 that most (81.2%) of the migrant workers were educated below secondary level.

Figure 7.2: Distribution of respondents by level of education



Source: Pratichi primary survey 2021

In terms of religious groups the respondents were highly skewed towards the community of Muslims (79.8%), with a share exceeding their population share in each of the three districts. The share of Hindu and Muslim population in the selected districts and among the surveyed population is given below.

Table 7.2: Distribution of population by religion in selected districts and survey samples

District	Hindus (in %)		Muslims (in %)	
	Census 2011	Sample	Census 2011	Sample
Birbhum	62.3	9.0	37.1	91.0
Murshidabad	33.2	0.0	66.1	100.0
Malda	48.0	37.0	51.3	63.0

Source: Bureau of Applied Economics and Statistics (2015) and Pratchi primary survey 2021

In most of the cases, the phone numbers of respondents were collected from agencies that recorded it from the points of reporting by the returnee migrants. The numbers were picked up randomly from the given list. Table 7.2 shows that migrants came mainly from the Muslim community and they were proportionately much higher than their share in the population in the concerned districts.

The family size of the migrants appears to be larger than average. The national and state (West Bengal) averages were respectively 4.45 and 4.48; it was 5.5 for the migrant families. The family size was a little higher for Muslims (5.6) as compared to that of the Hindus (5.3).

Multiple sources of income in a family are likely to have some advantage, i.e. if one avenue of opportunity dries up then the income shock may be somewhat absorbed by the other. This was particularly important at the time of the lockdown. But only 15 percent of the households had this luxury. Eighty five percent of the migrant families lived on a single source of income. It may be noted here that a single source does not necessarily refer to a single earner. A household, for example, with two earning members, may earn livelihoods from two different sources, say cultivation and trade. Almost all of the migrants (92%) earned their livelihoods by hiring out labour, indicating that they come from a poor economic background.

This condition of precariousness may be further noticed if we look at the age of first migration of these respondents, as they ventured out for earning money. It may be argued that children from poor households tend to hire out labour at an early age. Nearly nine out of ten (89%) respondents worked for money, before they attained the age of 20 years. Close to one out of five (19.3%) of them started this career below the age of 14 years.

Table 7.3: Distribution of households by sources of income

Source of income	Percentage of households
Hiring out labour	92.0
Cultivation	6.2
Selfemployment	5.4
Salaried*	5.0
Others	2.4

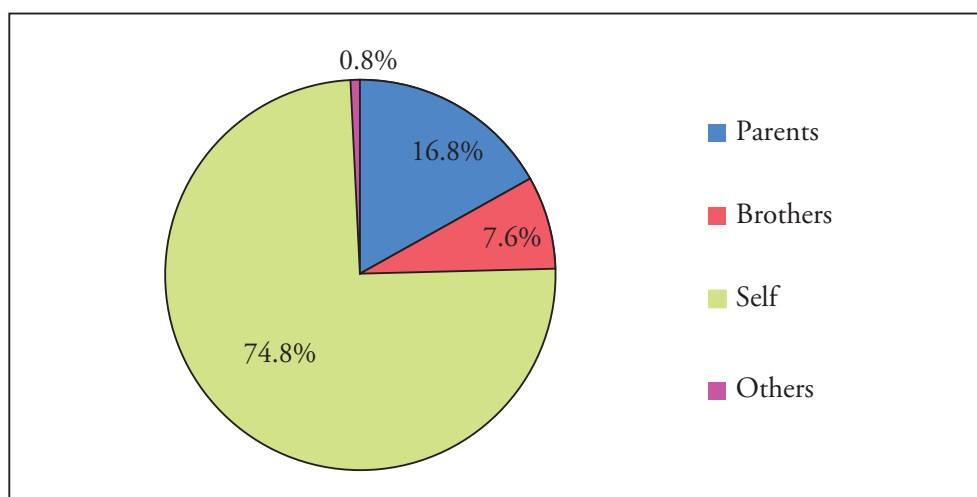
(Responses are not mutually exclusive)

Source: Pratichi primary survey 2021

*Generally lowly paid and includes workers of jewellery enterprises or shopping malls.

Significantly, 74.8 percent respondents were the main earners in the family. Their life was already precarious since they were poor and dependent mainly on a single earner, though not a daily wage. Getting entrapped in the situation like the lockdown would just add misery to the migrants themselves as well as to their family members at home. When the primary earner was other than the hapless migrant worker, the family could have a little respite, provided the earner still had a job.

Figure 7.3: Distribution of respondents by relation with their household heads



Source: Pratichi primary survey 2021

As far as skill training is concerned the migrants were found to be grossly under-trained. Only a negligible proportion of respondents (4 out of 500) told that they had received some sort of institutional training, and they were mechanical, computer, zari and tailoring workers. However, among the others, many were not new to their work that they had been performing in the destination. Particularly, many masons obtained the requisite skill by working in the local construction market. Some other migrants acquired skills (like tailoring) at the beginning of their migration and capitalized on it afterwards.

Destination of Migrants

The returnees were from many states including West Bengal itself. There were 18 states from where the migrants headed home. Forty one respondents (8.2%) returned from other districts of West Bengal including Kolkata, Howrah, Hooghly, Purulia, Bankura, Purba and Paschim Medinipur, Purba and Paschim Bardhaman, and Cooch Behar. The destination states may be grouped into four regions – i) Northern states (New Delhi, Hariyana, Uttar Pradesh and Uttarakhand), ii) Neighbouring states including Bihar, Assam, Jharkhand, Orissa, Nagaland and Chhattishgarh, iii) Southern states (Andhra Pradesh, Karnataka, Kerala and Tamil Nadu), and iv) Western states (Maharashtra, Rajasthan and Gujarat).

The share of migrants from these regions varied significantly. Most of the returning migrants (61.2%) were from the southern states (Table 7.4), the highest proportion (42.8%) being from Kerala.

Table 7.4: Distribution of migrants by destination

Region	Percentage of migrants
Northern states (New Delhi -10, Hariyana 20, Uttar Pradesh 6, and Uttarakhand 4)	8.0
Neighbouring states (Bihar 3, Assam 13, Chhattishgarh 2, Jharkhand 2, Nagaland 1, Orissa 24)	9.0
Southern states (Andhra Pradesh 12, Karnataka 18, Kerala 214, Tamil Nadu 62)	61.2
Western states (Maharashtra 63, Rajasthan 3, Gujarat 2)	13.6
West Bengal 41	8.2

Source: Pratichi primary survey 2021

Type of Work Performed in the Destination

In the destination the migrants were found to be carrying out a number of activities. The highest proportion of migrants worked as masons or their helpers. The others worked in garments and jewellery sectors, cold storage or were self employed. In the garments sector, they worked as tailors or 'product finishers', and in cold storage the workers mainly worked as head-loaders. Self employment meant working as hawkers, rickshaw pullers and so on.

The employer-worker relationship was found to diverge widely across sectors and locations. As far as construction and garments sectors were concerned, the migrants found their work through two channels – making direct contact with employers or via middlemen. The middlemen were of two types – local or migrant. The migrant workers employed in cold storage or jewellery shops had established direct contact with the employers. The hawkers would purchase goods from a businessman (who may be local or migrant) on credit and sell goods door to door.

The nature of this relationship direct or indirect had its own specific advantages and disadvantages. In the construction sector many workers struggled to find employers who could offer employment for a fairly long stretch of time. They were perennially in search of new assignments, and often forced to remain idle in between jobs. But if it were via a middleman then the flow of employment would remain relatively uninterrupted. In case of direct contact with employers the workers would get actual wage, but if it was via middlemen the latter would take their commission from the labourers. However, their monthly income was reported to be more or less the same irrespective of the connection between the employers and the workers.

In the garments sector the availability of work was not uniform round the year. The workers used to return home at the lean seasons and would be recalled by the contractor when the demand was high. There was not direct deduction from the earnings of workers by the contractors. Rather both of them would work on a piece rate basis.

In the jewellery sector, the interaction between the employer and the workers was direct and the payment of their salary would be made on a monthly basis.

Income and Expenditure in Destination

Average income and expenditure of a migrant worker per month, as our survey reveals, was in the order of Rs.17096 and Rs. 4417 respectively. Some of them however did not opt to work for an entire month. For example, those who worked as head-loaders in a cold storage preferred to work for 15 days or so at a stretch. Some of the respondents had reached their destination just a few days before the announcement of the national lockdown. Therefore, their reported earnings pertained to this brief period. In other words, the concept of monthly income was not applicable for some respondents in our survey. In calculating the average monthly income and expenditure, therefore, estimates were made on the basis of earnings that did not necessarily cover an entire month. The income ranged between Rs.0 and Rs. 53333 per month. Monthly income of a worker in the jewellery sector was Rs.16000. Monthly earning of self employed persons was Rs.16526. The amount earned by a piece rate worker was Rs.24250. It was Rs. 19014 for construction workers. The earning of skilled masons was higher than their helpers. The contractors earned the highest amount (Rs.53333 per month). Those working in cold storage expected to earn between Rs.800 and Rs1200 per day. When respondents are distributed according to income slabs we find an interesting picture. A majority of the respondents belonged to the income slab between Rs.10001 Rs.20000. The distribution of respondents by income slab is given in Table 7.5.

Table 7.5: Distribution of respondents by monthly income slab

Income slab (Rs)	Share of respondents (%)	Average monthly income (Rs)	Average monthly expenditure (Rs)	Net monthly income (Rs)
Upto 10000	12.2	9500	2463	7037
10001 -15000	34.4	13752	3902	9850
15001 -20000	31.0	18216	4945	13271
20001 -30000	21.2	24122	5434	18688
30001 -50000	1.0	44000	5350	38650
Above 50000	0.2	70000	18000	52000

Source: Pratichi primary survey 2021

The above Table (7.5) suggests that the remittable income was somewhere between Rs.7037 and Rs.52000. The remittable net income is an important concern for the migrants as this may be used for various purposes in the source area. Therefore, expenditure at destination is an important concern. Estimates reported by our respondents yielded an average monthly expenditure of Rs.4417 per migrant. This expenditure was roughly divided into three categories – food, accommodation and other expenses. Understandably, there was variation across categories as well as across classes of migrants. In a few cases, the worker did not incur any expenses.

Table 7.6: Distribution of respondents by monthly expenditure incurred on food

Expenditure slab (Rs)	% of respondents	Amount of average expenditure (Rs.)
No expenditure on food	14.8	2837
Upto 2000	14.6	
2001 - 3000	38.4	
Above 3000	32.2	

Source: Pratichi primary survey 2021

Table 7.7: Distribution of respondents by amount of monthly room rent paid

Rent slab (Rs)	% of respondents	Amount of average expenditure (Rs.)
No room rent	46.4	666
Upto 1000	31.8	
1001 - 2000	18.0	
Above 2000	3.8	

Source: Pratichi primary survey 2021

Other Essential Expenses

The average expenditure on the category called 'other' was Rs.914. Like in the categories of food and accommodation, the expenditure in this category too varied between individuals.

Table 7.8: Distribution of respondents by expenditure on other necessary things

Expenditure slab (Rs)	% of respondents	Amount of average expenditure (Rs.)
Zero expenditure	26.8	914
Upto 500	17.0	
501 -1000	33.4	
Above 1000	22.8	

Source: Pratichi primary survey 2021

It appears from the three Tables above (Table 7.6, Table 7.7, and Table 7.8) that some migrants could afford to live on practically zero expenses while others had to incur expenses to meet their basic needs of food and shelter. It was therefore doubly difficult for the latter to meet up these essential costs of living at the time of the lockdown when they were also out of job. In this connection it can be noted here that timely payment of wages that were due would have been a major relief for the migrants at this difficult hour. But 13 percent of the migrant workers (65 respondents) reported that they did not get their full dues from the employer. The average amount of such dues was as high as Rs.31431. But such dues were unequally distributed between contractors and labourers. The average dues of the contractors were Rs.3.5 lakh (highest being Rs.8 lakh) whereas it was Rs.15510 for labourers, i.e. close to a month's income.

Challenges before Migrant Workers due to the Lockdown

Jamirul Sekh of Malda district used to work in Kerala as a construction labourer. He used to earn around Rs.12000 per month. All expenses at his place of work met, he could save around Rs.8000. At the time of the lockdown, however, he was without any work for about 90 days. It was difficult for him to pay the house rent. Under pressure from his landlord to pay up the dues, Jamirul's wife sent him a borrowed sum of Rs.16000 to meet this and other necessary expenses.

Jamirul's hardship was far from unique, resonating with the pains of many other migrant workers. The challenges they faced were not limited only to employment losses in the destination, but also pertained to their arduous return journey as well as what they experienced in the source area upon their return. First of all, if we focus on employment, we find that over 93 percent migrants lost it. Another six percent earned some income but it was much less than earlier. Only a negligible (0.8%) proportion of migrants were lucky not to face any reduction in their income. It is difficult to imagine the misery of the migrants, who lost their employment and so income, but could not avoid essential expenditure for themselves particularly on food, shelter and some other necessary items, at the destination, and for their left-behind families at source. In the destination, migrants were not entitled to have access to existing social security schemes like

the PDS (one nation, one ration card is yet to be operational, at the time of completing this report). Moreover, they had limited informal social support over there, compared to their entitlements at home. It is not difficult to imagine how hard it is to bear with such a situation for long without any income or strong social support. Expecting that home would give them some relief, the migrants were returning home, in hundreds and thousands, poignantly visibilizing to the whole nation a hitherto invisible side of our social reality.

It appears from the data that different groups of migrant workers left destination at different points of time. It was found that some migrants left for home almost immediately after the announcement of the lockdown whereas some others returned later, even a long time after the lifting of the restriction of lockdown. There were some cases in which migrants did not return at all even at the time of interview, that went on for the period between January and April 2021. Why some people headed home immediately after the announcement of lockdown while others stayed back in the destination for a longer period is a crucial question. Varied degrees of compulsion and varied sets of opportunity appear to be the possible reasons.

Table 7.9: Distribution of respondents by the time they took to decide whether to return home

Duration (days)	Percentage of respondents
Up to 10 days	13.4
11 - 36 days	30.4
37 - 60 days	31.7
61 - 90 days	18.6
Above 90 days	5.9

Source: Pratichi primary survey 2021

According to our survey, the proportion of migrants who were on the way to home within 10 days of the announcement of the lockdown was 13.4 percent. The degree of compulsion was very high for these migrants. This compulsion may be related to non-availability of accommodation and employment. The labourers working in cold store is a case in point. They returned soon after the announcement of the lockdown, being forced by a combination of reasons that included loss of employment, refusal of accommodation (where they used to stay

free of cost), lack of hope of resumption of work within a manageable time period and their resolve to cover the distance to their residence on foot.

Another 30.4 percent of the migrants returned during the period between 11 and 36 days. It appeared that this group of migrants had some fall-back provisions to cope with the emerging challenges. In addition, the distance to home was not manageable on foot. The migrants in Assam belong to this group. They used to earn their livelihoods as vendors, i.e. by selling utensils from door to door. The *Mahajon*, who was also a migrant, would supply them goods on credit. After imposition of the lockdown the *Mahajon* offered them accommodation and food on credit. Nonetheless, they were keenly looking forward to an opportunity to return home since they were not sure how long the lockdown would continue and meanwhile they had to incur some expenditure. So, in about three weeks, when they found a vehicle that agreed to take them home and that the *Mahajon* was willing to give loan to pay the fare, they immediately left for home.

The distance between home and place of work was a major barrier to taking the return journey especially for those who were working in areas like Delhi, Maharashtra, Kerala etc. Almost all of them were very keen to return home but the situation did not allow them to do so, lack of transportation being the biggest problem. In addition, in some cases they had to fulfill some formalities like obtaining permission, from the governments in the destination as well as at source, to leave and enter respectively. When the '*Shramik Special*' trains started to operate from May 1, 2020 (i.e. 37 days from the date of announcement of the lockdown) returning home became somewhat easier and more than 50 percent of returning migrants returned after that. Support received from various sources in the destination was crucial for the migrants to manage their stay over there for a long stretch of time, without any income (as detailed later).

Some migrants decided to stay back for quite some time in the destination even when there was almost no restriction to travel. Food support from various sources in destination, affordability to pay for food and shelter from savings, availability of wage-work etc were some of the possible reasons that helped them to sustain themselves during this period. For example, the workers in the garments sector in Andhra Pradesh had enough money in hand (because of higher income) to

manage through this period. In addition, occasionally they were assigned the work of making masks and PPE kits (their use was widely recommended to combat COVID-19). Apart from that, they had to pay nothing for their accommodation. But many other migrants were not so lucky. Hasinur Jamal of Malda, for example, had to pay the full amount of rent (Rs. 1200 per month) during his stay in the destination.

Challenges on the Journey

Monirul Islam, along with some co-migrants, migrated to Uttar Pradesh from Birbhum of West Bengal. They used to sell mosquito nets from door to door riding bicycles. With the same bicycles they rode back home, which was around 700 kms away, travelling for six days. "One day we were making arrangement to sleep in an empty varanda of a deserted house in a village. The residents from around did not allow us to do so. We were not even allowed to eat there. They drove us out. So we resumed our bicycle ride. Sometimes we spent our nights in buildings under construction, away from any locality. Sometimes it was under a tree. On the way, a banana seller refused to sell us bananas."

Many migrant workers faced similar challenges en route. The challenges were more for those who were travelling by bicycle or on foot. In our study it was found that 40 migrants (8%) walked and/or cycled either the entire stretch of their travel or a part of it. The longest distance voyaged by cycle was reported to be 700 km.

Table 7.10: Distribution of respondents by distance travelled back home on foot/cycle

Range of distance (km)	Number of persons travelled
Up to 50	21
51 - 100	4
101 - 200	4
Above 200	11
Total	40

Source: Pratichi primary survey 2021

The other respondents travelled by some means of transport, including bus, train (paid and unpaid), lorry, auto rickshaw, car, ambulance and airplane. Often they combined more than one mode of transport. Only 26.8 percent of returnee

migrants reported that they were contacted by authorities of the Government of West Bengal or by any non-government agencies (NGOs) for the purpose of their return. In most of such cases it was from the end of the government.

Table 7.11: Means of transport availed by migrants to return home

Means of transport	Percentage of respondents*
Bus	46.2
Train	50.2
Flight	5.0
Walking / cycling	8.0
Others/own arrangement (hired car, lorry, ambulance, auto rickshaw etc)	27.4

Source: Pratichi primary survey 2021

*Responses are not mutually exclusive as migrants often had to choose a combination of transport facilities.

Ill-treatment of Migrants

Maltreatment with migrants during the lockdown has been well reported in the public media. Spray of pesticide, refusal of shelter (even for a short term), refusal of water from tube-wells and food from shops were some such examples of maltreatment. Good experiences were also reported. There were reports that migrants on the way were offered food and other essentials. All these reports together suggest that the migrants had a mixed experience. This is confirmed by our survey too. Ill-treatment was received mainly by those who travelled back on foot or cycle, though not limited to them only. Forty five migrants out of our total respondents reported that they were harassed in various ways. In most cases (37) the harassment was caused by the police and public authorities. In some cases individual persons or groups of individuals harassed them. Harassment from multiple agencies was also reported. For instance, while a group of migrants was walking back home from Medinipur, the police of East Burdwan stopped them on the way and dropped them by car back at a place which they had already travelled. Some of them were not allowed to walk through some villages or buy things from the shops there.

Twenty two migrants reported enduring physical impairments and injuries on the way. This included illness due to arduous trips, with limited personal wherewithal and inadequate public arrangement. Some migrants sustained foot injuries on

their long walks. Some others got too tired of walking at a stretch, for an unendingly long time.

Support for Migrants in the Destination

The support received by migrants in the destination was from various sources including the employers, governments at source as well as destination areas, individuals as well as collective social activists, non-governmental organizations, landlords of rented house and so on. The type of support may be divided into categories of food, accommodation, medical assistance and cash. A section (41.8%) of migrants did not receive any support from their employers (some of them might have been the beneficiary of other sources of support). Food and accommodation support was received by 32.6 and 39.0 percent of migrants respectively. The support in the form of cash was received by 3.8 percent of migrant workers. Cash support was generally a token amount which was either one time, monthly or weekly. Food support was also of a similar nature. Apart from the support from employers, 35 migrants received support from other sources. For example, sometimes the landlord in question provided food and/or exempted the rent.

There was evidence of support provided by the government at source area (Govt. of West Bengal in this case) as well. Dalim Sk stayed unemployed in Kerala for 72 days. At that time he called 'Didike Bolo' and described his distress. Consequently he received Rs.3000 in his bank account. The local government in the destination also provided some support. Jamal Sekh of Malda received rice and dal from the Kerala government. Similar support was reported by migrants in Assam and Mogholsarai as well. In another incident the Bangla Sanskriti Mancha provided food support to a group of 40 migrants for 20 days when they were stuck in Mumbai. All this support gave some crucial relief to the migrants during the days of their jobless existence in the destination.

It is apt to mention here that some migrant workers used to receive some sort of assistance in the normal times too. The survey reveals that 46.4 percent of the respondents did not have to pay for their accommodation. There was no expenditure on food and other necessary things for 14.8 and 26.8 percent of the

migrants respectively. Twenty seven respondents, i.e. 5.4 percent, reported that they had to pay for nothing (on food, accommodation and other essential things) in the destination. A part or all of these facilities were available even at the time of the lockdown. For example, masons who stayed in the worksite did not have to pay for their accommodation. However, on the other hand, it also suggests that many others had to pay for things necessary for their subsistence. Without any income, it is very difficult to pay for these items.

Support during the Journey

The migrants received support on the journey as well. The police of Bhatar Police Station in the East Burdwan district offered money to a group of walking migrants, who were travelling from Hooghly district to Murshidabad district, to help them hire a car. Similarly, the group of migrants, who were cycling back from Mogolsarai to Birbhum, was offered food by Bihar police. The migrants who travelled from distant states like Andhra Pradesh, Kerala, Maharashtra, Delhi etc reported that lots of food and water were distributed in many places on their journey by various agencies.

During their return journey 61.4 percent of the respondent migrants received support in the form of food, transport cost, free bus and train rides etc. Among them, 91 percent received food and 30 percent received support in other forms. Only 113 migrants (22.6%) reported that they got the opportunity to travel by train, bus or car free of cost. Such arrangements were made mainly by government agencies including the Government of West Bengal. In some cases the migrants received a combination of different forms of assistance mentioned above.

The other migrants had to manage their travel costs (partly or fully) in various ways, including use of own savings (39%), money sent from families (21.2%), loan from employers or others in the destination (5%) etc. The families that sent money to bring back the migrants had to manage the extra sum in a variety of ways including sale of crops and mortgage of ornaments.

Old Home, New Experience

“Peter jwalai bideshe kaj korte jai amra. Valo incomer asbai. Kintu tinmas Keralate atke

theke bujhlam sudhu nijer poribar-i apon. Baki sob jallad. Sukno muri kebey pore thakbo nijer jaigai. Tobu ar bidesh jabo na. (Driven by hunger, we migrate with the hope of better earning. But having got stuck for three months in Kerala [during the lockdown] I have realized that it is only my family that is dear to me and that matters. All others are like hangmen. We would rather live off on puffed rice than migrate again.” (Md. Mofazul, 25, Malda).

Migrants like Mofazul, who believe that their family is the most secure place, are quite large in number, and understandably so. Perhaps that's why the migrants headed home located in the place of origin. But often the home was strange and odd, i.e. different from that in the normal times. First of all, there were many formalities to be completed before one could enter his own home. They were supposed to report their arrival at some designated points. Arrangements were made by the Government of West Bengal accordingly so that it could keep vigil on them and take necessary action to curb the spread of the Corona virus in the event they were sick. The major points of reporting included Health Centres/camps, Police Stations, BDO (Block Development Officer) offices etc. Health camps were organized at designated spots, particularly for those who returned by train. Some migrants had to report at multiple check points whereas some others did not report at all.

Table 7.12: Distribution of respondents according to points of reporting

Points of reporting	Percentage of respondents*
Police Station	25.6
Health Centres including camps	54.2
Gram Panchayat	6.6
Other officials including ASHA workers	24.0
Nowhere	6.8

Source: Pratichi primary survey 2021

*Responses are not mutually exclusive

Experience, in relation to reporting, was not very pleasant in many cases. Often reporting at check points was time consuming and after a long journey it was too exhausting. Experience of Abdur Rahim of Bolpur Block, Birbhum, may shed some light in this regard. He returned from Andhra Pradesh by bus, travelling for more than 30 hours. At first he reported at around 8 am to the local Police Station, which then referred him to the local Health Centre. He was supposed to go home only after receiving clearance from there. He was not examined by any

doctor in the Health Centre. At around 2 pm he received his clearance paper which was nothing but a stamped document with his name written on it. Similar experience was reported by the migrants from Nanoor block of the same district as well.

The returnee migrants were suspected to be potential spreaders of the Corona virus. So the idea was to isolate them from the local people for certain period. Some of them were kept in government quarantine centres whereas others were asked to quarantine themselves at home. Of the total respondents, 44.2 percent were sent to institutional quarantine centres. The duration of stay was for 12 days (on an average), varying from case to case. It was for a period between 1 and 10 days for 29.4 percent of them. A higher proportion (49.3%) of migrants stayed in the quarantine centre for a longer stretch (11-14 days). Still another section of migrants (21.3%) stayed for more than 14 days.

Table 7.13: Distribution of migrants according to the length of their stay in quarantine centres

Length of stay	Percentage of migrants
Up to 10 days	29.4
11 -14 days	49.3
Above 14 days	21.3

Source: Pratichi primary survey 2021

Often the experience of stay in the quarantine centre was unpleasant. Regular check up by doctors was important for those staying in quarantine centres. But only 44 percent of them reported having been examined by any doctor. In addition, there was almost a common complaint about the quality and quantity of food, served over there.

Apart from confinement at the institutional quarantine centres, 55.8 percent of the migrants were allowed to stay in home isolation. It may be noted here that while 69 percent of these migrants followed the instructions and restrictions pertaining to home isolation, the other 31 percent did no such thing, partly because their circumstances did not allow them to do so.

Furthermore, the returnee migrants were looking for solace and freedom from tension at home. But, this time the home too was like an alien place. Being at home

was not like what it had been in normal times for a group of migrants. In normal times, generally, in the first few days after their return they would enjoy socializing with their close ones and neighbours. But this time, many migrants felt that they were unwelcome. As Md. Alauddin of Nanoor, of Birbhum, felt, people in their area were looking at their family with an unsympathetic eye. Even when the quarantine period was over, he therefore felt hesitant to interact with them.

The home had its own added burden too, particularly for those, who were among the poorer sections of the area and were in debt to others. Some of the migrants could afford to return home only after taking loan from others. Without any regular flow of income – however meager – it was hard to meet even essential family expenditures. Consequently, about two thirds (65.4%) of the respondents faced shortage of food during the lockdown. The government surely provided some food grains through the PDS that met a part of the need of these families. But 26 households (5.2%) fell out of the ambit of this minimum food safety net because they did not have any ration card. About two thirds (65.4%) of these card-less households (n=26) reported to have faced food shortage, whereas it was about one third (33.4%), taking all the respondents together (n=500). Such a situation pushed 43.8 percent of these migrants to hire out labour in the local employment market, within a short period of time. Though the wage rate was low, the meals of the family members could be arranged with such earnings. Meeting up other essential expenses was however not within the horizon of possibility. For example, Ajinul Sekh could not meet up the cost of his daughter's education any more. So these people were destined to migrate out, sooner or later.

The employment market worldwide, including that for the migrants, has been affected by the lockdown. Therefore, migrants were not sure about getting back their employment. Only 60.6 percent of the respondents were hopeful that they would get back their job upon return, whereas 17.6 percent of the respondents were not so sure. Only 5.2 percent of the respondents, however, thought that they would not get back their previous job. Whether this is a ray of hope only time will tell.

The importance of migration is once again revealed from the picture of re-migration. Over two thirds (67.2%) of the migrants had already re-migrated at

the time of our interview. Another 16 percent was planning to migrate soon. About another 16 percent was reluctant to migrate again.

Table 7.14: Distribution of respondents according to their willingness to re-migrate

Particulars	Percentage of respondents
Already re-migrated	67.2
Willing to migrate soon	16.0
Unwilling to migrate	16.0
Others	0.8

Source: Pratichi primary survey 2021

Of those who were unwilling to migrate again, about 65 percent was planning to continue hiring out labour in the local employment market, whereas a few (7.5%) were planning to do some business. This indicates that hiring out labour, even at low wage rates, is the major livelihood option in the source area.

Table 7.15: Distribution of respondents, unwilling to migrate, by their future plan of livelihoods

Plan of earning livelihood	Percentage of respondents
Hire out labour in the local employment market	65.0
Planning to do some business	7.5
Planning to do something else	27.5

Source: Pratichi primary survey 2021

Concluding Summary

More than 11.5 percent of the population has been termed as employment-related migrants in the census of 2011. A large part of this migrant community belongs to those who live below poverty line. The income earned in the destination appears to be higher than what they could have earned in their local employment market, suggesting that migration has high potential in poverty reduction. Consequently, it can help improve the capability of people through access to better services, in terms of health and education, for their family members.

The development impact of migration is not limited to source areas. Services and production in the destination area are also likely to be affected without the supply of migrant workers. Thus migrants may make substantial contribution to the

development of our country. Nonetheless, migrants were put under an extremely trying situation at the time of the national lockdown. Our data suggests that:

Migrants tend to spend their golden age of life in the destination, as most of the migrants belong to the age group of 20-39 years. A majority (51.4%) of the migrants was in the age group of 20-29 years, followed by the group of 30-39 years (28.0%).

Migrants were not well endowed with educational resources. Only one out of five migrants attained the level of secondary education and above.

As reflected in the occupational pattern the migrants, they were basically from poorer backgrounds. The main source of their family income was hiring out labour (92% cases). It was cultivation for only 6.2 percent of the migrants.

With respect to religion and gender, they were disproportionately distributed. Almost four out of five (79.8%) migrants belonged to the Muslim community and the rest belonged to Hindus.

Almost all migrants were male.

The migrants did not migrate only to other states. Rather a section of the migrants returned from other districts of West Bengal itself. The rest of the migrants returned from 17 other states. More than six out of ten (61.2%) migrants returned from the southern part of the country. Kerala alone was destination for 43 percent of the migrants.

The migrants in the destination worked as wage labour (mason and helper) in construction sector and cold stores, in the garments manufacturing sectors and jeweler companies, or were self employed. There was a complex relationship between employers and labourers.

Average monthly income and expenditure was Rs. 17096 and Rs. 4417 respectively. Monthly income was more than Rs.10000 for 87.8 percent of the migrants. More than 54 percent of the migrants earned Rs.15000 and above a month. The highest reported income of a migrant was Rs.70000.

Migration appears to be the destiny of most of the migrants. A majority of the respondents (67.2%) reported that they had re-migrated. Another 16 percent was going to migrate soon.

A little over 46 percent of the migrants had free accommodation in the destination; and 14.8 percent were fortunate to have incurred zero expenditure in the host state during the normal times.

Most (93.2%) of the migrants lost their employment due to the lockdown.

Only 13.4 percent migrants returned home within 10 days since the lockdown.

Some (5.8%) stayed in the destination for more than ninety days. More than 50 percent of them returned after May 1, 2020, when the *Shramik Special* train began to run.

Support for food and accommodation in the destination during the lockdown was received by 32.6 and 39 percent of the migrants respectively. Cash support from employers was received by only 3.8 percent of the respondents.

Migrants received support from other sources in terms of free food and accommodation. 32.6 percent of the migrants received food support for either a part or the entire period of their stay in the destination. 39 percent of them were exempted, partly or fully, from paying for their accommodation.

Eight percent of the returning migrants travelled, in part or through the entire journey, on foot or by bicycle. The longest distance travelled by the migrants by bicycle and on foot were 700 km and 250 km respectively.

Bus and train were means of transport for 46.2 and 50.2 percent of the returnee migrants. Only 22.6 percent of them returned by train free of cost. Others had to pay for transport somewhere between Rs.2500 and Rs. 10000.

Experience of journey back home was mixed. Nine percent of the migrants faced some sort of harassment which was caused mainly by police or some other public authority. Evidence of good treatment meted out by the police was also available.

The issue of labour migration needs to be carefully addressed in the light of the tremendous hardship that this largely ignored and invisibilized section of the country's laboring class has had to undergo during the national lockdown. That the policy responses to contain the bio-medical pandemic caused a kind of socio-economic pandemic for this section of our citizenry is a lesson that a democratic India cannot afford to overlook.

In Lieu of a Conclusion

At the time of writing these concluding pages, a third phase of the Corona contagion is unfolding at a brisk pace in different parts of the country, confirming the truism that the pandemic is yet to put an end to itself. To bring a closure to the narrative of the COVID-19 crisis is, therefore, premature. So we refrain from presenting any definitive conclusions at the end of this report regarding a crisis that is on-going and about responses to the same that too are in progress.

But chronicling, no matter how in-exhaustively and partially, the interim processes and intervening responses that have been undertaken by various public authorities and agencies to deal with the diverse facets of this multidimensional pandemic is itself a response on our part to this crisis. Our aim has been to keep a record, for future research and action, of the remedial steps that have been tried or missed out by those who are at the helm of policy management as well as by the community in general. This, we submit, is our modest mode of research-informed activism in the vast sea of pandemic-triggered societal activism all around us.

Of the many insights that we have gleaned from this study about governmental and other collective responses to the pandemic-generated social injuries that have particularly dented the lives and life-chances of the masses, we only reaffirm two here that encapsulate the spirit of several others.

First, the longstanding, well-considered, but oft-flouted vision about the critical role of public institutions and services in empowering people with basic capabilities has come to its full relief during the pandemic. People seem to have rediscovered that public schools matter, tax-financed universal basic healthcare matters equally if not more, that the public health system and its cadre need to be strengthened manifold, and that public guarantee of basic food and livelihood security are the essential correlates of decent living in all seasons—pandemic or endemic. No matter how common the perception has remained so far about the

so-called quality appeal of market institutions, during most of the pandemic season the private market seems to have been conspicuous by its absence. Thus, societal challenges that the pandemic has created have demanded and also yielded collective solutions, although not necessarily optimal. Governmental efforts, in particular, have been found to be in need of significant acceleration.

Second, the findings of this study have resonated with the perceptive comment that Professor Amartya Sen has made about viewing the crisis time as a period and occasion of collective endeavour to combat shared predicaments. During our telephone/online conversations with our respondents – household members, grassroots health workers, ration dealers, school teachers, NREGA staff, migrant workers, panchayat members, ward councillors and so on – what has sounded in ringing notes are the accounts and narratives of working together in a network of collaboration to cope with the unprecedented challenges thrown up by the pandemic. Individual coping strategies are found to have been supplemented by communal support, ranging from modest to momentous. Surely, there have been failures, oversights, and instances of cruel indifference vis-a-vis people's woes, as also institutional inertia and deficiencies in coming up with responses and resources that could have better secured people's basic entitlements during these extraordinary times. But, on balance, we have noticed an assertion of a social ambition to stand in solidarity with others; this affirms the public-spirited outlook that informs this report.

References

- Acharya Rajib, Porwal Akash (2020), 'A Vulnerability Index for the Management of and Response to the COVID -19 Epidemic in India: An Ecological Study', *The Lancet Global Health*, 8 (9).
- Agarwal Bina (2021), 'Reflections on the Less Visible and Less Measured: Gender and COVID-19 in India', *Gender and Society*, 35 (2).
- Alston Philip (2019), 'Statement by Professor Philip Alston', United Nations, OHCHR, August 23.
- Alvi Muzna, Gupta Shewta, Meinzen-Dick Ruth, and Ringler Claudia (2020), *Phone Surveys to Understand Gender Impacts of COVID-19: A Cautionary Note*, Washington DC: International Food Policy Research Institute.
- Aman, G N Thejesh, Ranaware Krushna and Sharma Kanika (2021), 'Of Denial and Data: Deaths due to India's COVID-19 Lockdown', *Economic and Political Weekly*, 56 (23).
- Anandabazar Patrika (2021), *Sudhui Nirdeś*, (In Bengali) Editorial, 24 May.
- Azcona Ginette, Bhatt Antra, Encarnacion Jessamin, Plazaola-Castano Juncal, Seck Papa, Staab Silke, and Turquet Laura (2020), *From Insight to Action: Gender Equality in the Wake of COVID-19*, UN Women.
- Bagchi Suvojit (2020), 'India's Next Nightmare: Experts Fear Measles Outbreak as Covid Disrupts Child Immunisation Programme', *HuffPost*, August 14, Accessed from https://www.huffpost.com/entry/indias-next-nightmare-experts-fear-measles-outbreak-as-covid-disrupts-child-immunisation-programme_n_5f36f6c3c5b6959911e4706a on December 05, 2021.
- Bajaj J K (2011), *Food Consumption in India and the World*, Centre for Policy Research, Accessed from <http://cpsindia.org/index.php/art/123-articles-by-jk-bajaj-and-md-srinivas/food-consumption-in-india-and-the-world> on May 20, 2021.
- Begum Farhana (2021), 'Perception of COVID-19 in Bangladesh: Interplays of Class and Capital', *Society and Culture in South Asia*, 7 (1), SAGE.

BEHANBOX (2021), *Female Frontline Community Healthcare Workforce in India during COVID-19: A Report*.

Bhaduri Soham D (2020a), 'The Criticality of Community Engagement', *The Hindu*, April 6.

Bhaduri Soham D (2020b), 'Changing Our Approach Towards Mask Use', *The Hindu*, June 22.

Bhalotia Shania, Dhingra Swati and Kondirolli Fjolla (2020), *City of Dreams No More: The Impact of COVID-19 on Urban Workers in India*, A CEP COVID-1 Analysis, Paper No. 008, Centre for Economic Performance, LSE.

Bhattacharya Swati (2020), 'Era Kivabe Dekhbe Bharotke', (in Bengali) *Anandabazar Patrika*, May 19.

Bhattacharya Swati (2021), 'Jekhane Mask Charai ASHA Kormeeke CORONA Juddhe Pathano Hochhe', (in Bengali) *Anandabazar Patrika*, April 27.

Bunch Will (2020), 'Disaster Socialism: Will Coronavirus Crisis Finally Change How Americans See the Safety Net?' *The Philadelphia Inquirer*, March 12.

Bureau of Applied Economics and Statistics (2015), *State Statistical Handbook 2014*, Government of West Bengal.

Child Rights and You (CRY) (2020), *Rapid Online Perception Study about the Effects of COVID-19 on Children*, New Delhi, Accessed from https://www.cry.org/wp-content/uploads/2020/05/Report-CRY_COVID-19-Study.pdf on September 07, 2021.

Chmielewska Barbara, Barratt Imogen, Townsend Rosemary, Kalafat Erkan, Meulen Jan Van Der, Gurol-Urganci Ipek, O'Brien Pat, Morris Edward, Draycott Tim, Thangaratinam Shakila, Doare Kirsty Le, Ladhani Shamez, Dadelszen Peter Von, Magee Laura, and Khalil Asma (2021), 'Effects of the COVID-19 pandemic on maternal and perinatal outcomes: a systemic review and meta-analysis', *The Lancet Global Health*, 9 (6).

COVID-19 Outbreak Control and Prevention State Cell (2020_b), *Daily Bulletin*, Date: 24/03/2020, Health and Family Welfare Department, Govt. of Kerala, Accessed from <https://health.kerala.gov.in/bullattin/march/english/march-24.pdf> on April 14, 2021.

COVID-19 Outbreak Control and Prevention State Cell (2020), *Daily Bulletin*, Date: 24/04/2020, Health and Family Welfare Department, Govt. of Kerala,

Accessed from <https://health.kerala.gov.in/bullattin/april/english/April-24.pdf> on April 14, 2021.

Damodaran Harish (2015), 'Socio Economic Caste Census: Landlessness High in Kerala, West Bengal Despite Land Reforms', *The Indian Express*, July 9, Accessed from <https://indianexpress.com/article/india/india-others/landlessness-high-in-kerala-west-bengal-despite-land-reforms/> on December 21, 2021.

De Amrita (2021), 'India's Average Infant Mortality Improves, But Some States Lag Behind', *IndiaSpend*, Accessed from <https://www.indiaspend.com/data-viz/indias-average-infant-mortality-improves-but-some-states-lag-behind-789409> on December 11, 2021.

Department of Economic Analysis and Research (No date), *Doubling of Farmers' Income by 2022: Issues and Strategies for West Bengal*, National Bank for Agriculture and Rural Development.

Department of Food and Supplies (No date¹), *Report at State Level*, Government of West Bengal, Accessed from [https://wbpd.s.wb.gov.in/\(S\(b5hxy2h3j0lmspadhuhenb1\)\)/RCCount_District.aspx](https://wbpd.s.wb.gov.in/(S(b5hxy2h3j0lmspadhuhenb1))/RCCount_District.aspx) on May 9, 2021.

Department of Food and Supplies (No date²), *Ration Card Entitlements*, Government of West Bengal, Accessed from [https://wbpd.s.wb.gov.in/food/\(S\(pcd5agkud4itmeup1mj1rky\)\)/Homepage/entitlement.aspx](https://wbpd.s.wb.gov.in/food/(S(pcd5agkud4itmeup1mj1rky))/Homepage/entitlement.aspx) on May 9, 2021.

Deshpande Ashwini and Ramachandran Rajesh (2020), 'Differential Impact of COVID-19 and the Lockdown', *The Hindu*, August 8.

Dreze Jean (2020), 'The Need for a Million Worksites Now', *The Hindu*, May 25.

Dreze Jean and Paikra Vipul Kumar (2020), 'The Uneven Decline of Health Services Across States during Lockdown', *The Wire*, October 5.

Giridhar R Babu, Banaji Murad and Srinivasan Rukmini (2021), 'States Which Are Hiding COVID Cases and Deaths Are Disempowering Their People', Interview with Govindraj Ethiraj, *IndiaSpend*, April 25.

GoI (2019), *MGNREGA: PRC Presentation*, Accessed from <https://rural.nic.in/sites/default/files/MGNREGA%20PRC%20Presentation%201401%20Final.pdf> on May 8, 2021.

GoI (No date), Pradhan Mantri Garib Kalyan Package (PMGKP): Fulfilling Promise of Relief amidst COVID-19, Accessed from <https://www.india.gov.in/spotlight/pradhan-mantri-garib-kalyan-package-pmgkp> on November 10, 2021.

GoWB (No date), 'Agriculture', *Egiye Bangla*, Accessed from <https://wb.gov.in/departments-details.aspx?id=D170907140022669&page=Agriculture#:~:text=West%20Bengal%20is%20predominantly%20an,holding%20is%20only%200.77%20ha> on May 24, 2021.

Goyal Anuj and Tamang Laavanya (2022), 'Questions on MGNREGA Budget Estimation', *The Hindu*, February 22.

Goyal Manu, Singh Pratibha, Singh Kuldeep, Shekhar Shashank, Agrawal Neha and Misra Sanjeev (2020), 'The Effect of the COVID-19 Pandemic on Maternal Health Due to Delay in Seeking Healthcare: Experience from a Tertiary Centre', *International Journal of Gynaecology and Obstetrics*, 152 (1).

Greenhalgh Trisha, Jimenez Jose L, Prather Kimberly A, Tufekci Zeynep, Fisman David, Schooley Robert (2021), 'Ten Scientific Reasons in Support of Airborne Transmission of SARS-CoV-2', *The Lancet*, 397 (10285).

Health and Family Welfare Department (2020_a), *Bulletin*, Date: 24.03.2020, Government of West Bengal, Accessed from [https://www.wbhealth.gov.in/uploaded_files/corona/33445566-converted_\(1\)1.pdf](https://www.wbhealth.gov.in/uploaded_files/corona/33445566-converted_(1)1.pdf) on April 30, 2020.

Health and Family Welfare Department (2020_b), *Bulletin*, Date: 24.04.2020, Government of West Bengal, Accessed from https://www.wbhealth.gov.in/uploaded_files/corona/Bulletin_West_Bengal_24.04_.2020_.pdf on May 14, 2021.

Health and Family Welfare Department (2020_c), *Bulletin*, Date: 11.03.2020, Government of West Bengal, Accessed from https://www.wbhealth.gov.in/uploaded_files/corona/Bulletin_West_Bengal_11.03_.2020_.pdf on April 30, 2020.

Health and Family Welfare Department (2020_d), *Bulletin*, Date: 31.03.2020, Government of West Bengal, Accessed from https://www.wbhealth.gov.in/uploaded_files/corona/bul31-01042020173506.pdf on October 14, 2020.

Hirschman Albert O (1971), *A Bias for Hope: Essays on Development and Latin America*, New Haven: Yale University Press.

HMIS (No date), *Standard Reports*, National Health Mission, Accessed from https://nrhm-mis.nic.in/hmisreports/frmstandard_reports.aspx on May 19, 2021.

Human Rights Council (2020), *The Parlous State of Poverty Eradication: Report of the Special Rapporteur on Extreme Poverty and Human Rights*, 15 June-3 July, 2020.

REFERENCES

ILO (International Labour Migration) (2021), *ILO Global Estimates on International Migrant Workers: Results and Methodology*, Geneva: International Labour Office.

International Institute for Population Science and Ministry of Health and Family Welfare, GoI (No date), *National Family Health Survey 5 (2019-20): State Fact Sheet: West Bengal*, Accessed from http://rchiips.org/nfhs/NFHS-5_FCTS/FactSheet_WB.pdf on November 20, 2021.

Jayaram Nivedita and Varma Divya (2020), 'Examining the 'Labour' in Labour Migrations: Migrant Workers' Informal Work Arrangements and Access to Labour Rights in Urban Sectors' *The Indian Journal of Labour Economics*, 63 (999-1019).

John T Jacob and Seshadri M S (2020), 'Clear the Fog, Draw up a Clear Vaccination Policy', *The Hindu*, November 30.

Kanjilal B, Mukherjee M, Singh S, Mondal S, Barman D and Mandal A (2007), *Health, Equity and Poverty: Exploring the Links in West Bengal, India, Future Health Systems Research Monograph India*, Accessed from www.futurehealthsystems.org on August 14, 2014.

Khatua Sarani (2020), 'Density, Distancing, Informal Settlements and the Pandemic', *Economic & Political Weekly*, 55 (20)

Khera Reetika (2021), 'The Wages of Low Public Spending on Child Nutrition Programmes', *The India Forum*, April 6.

Klein Naomi (2007), *The Shock Doctrine: The Rise of Disaster Capitalism*, Canada: Knopf.

Kumar A K Shiva (2020), 'Where is Health in the Stimulus Package?', *The Hindu*, May 18.

Kumar Arjun (2014), 'Estimating Rural Housing Shortage', *Economic & Political Weekly*, 49 (26-27).

Kumar C, Sodhi C, and Jaleel CP A (2020), 'Reproductive, Maternal and Child Health Services in the Wake of COVID-19: Insights from India', *Journal of Global Health Science*, 2(2).

Kumar Praduman, Joshi P K and Birthal Pratap S (2009), 'Demand Projection for Foodgrains in India' *Agricultural Economics Research Review*, 22 (237-243).

Kumar Uttara Bharath (2021), 'Behavioural Change Can Reduce Transmission', *The Hindu*, June 7.

Mahanirban Calcutta Research Group (MCRG) (2020), *Borders of an Epidemic: COVID-19 War and Migrant Workers* (edited by Ranabir Samaddar), Kolkata.

Maira Arun (2021), 'India Does Not Shine When Only Some Gleam', *The Hindu*, March 31.

Mander Harsh (2020), 'An Invisible Humanitarian Crisis in India', *The Hindu*, August 07.

Ministry of Health and Family Welfare (No date), 'What Benefits Would Pregnant Women Receive', *Pradhan Mantri Surakshit Matritva Abhiyan*, Government of India, Accessed from <https://pmsma.nhp.gov.in/i-am/pregnant-woman/what-benefits-would-pregnant-women-receive/> on December 05, 2021.

Ministry of Health and Family Welfare (No date¹), *Immunization Services during and post COVID-19 Outbreak*, Accessed from <https://www.mohfw.gov.in/pdf/3ImmunizationServicesduringCOVIDOutbreakSummary150520202.pdf> on December 10, 2021.

Ministry of Housing and Urban Poverty Alleviation (2017), *Report of the Working Group on Migration*, Government of India.

Ministry of Statistics and Programme Implementation (No date), *Children in India-2018: A Statistical Appraisal*, Government of India, Accessed from https://www.thehinducentre.com/resources/article23966426.ece/binary/Children_in_India_2018_A_Statistical_Appraisal on November 10, 2021.

Mission Director (NHM) (2020), *D.O No. V-18015/4/2020_NHM-II*, National Health Mission, Accessed from https://nhm.gov.in/New_Updates_2018/In_Focus/2DO_AS_MD_ASHA_incentives.pdf on November 10, 2021.

Mission Director (NHM) (2020), *D.O No. NHSRC/20-21 /EDsectt/ Covid19/04*, National Health Mission, Accessed from https://nhm.gov.in/New_Updates_2018/In_Focus/1COVID_19_Guidance_note_on_operationalizing_actions_at_outreach_and__2_.pdf on November 10, 2021.

Mohanty Basant Kumar (2021), 'Poor Budget Allocation for Nutrition Schemes: Unkindest Cut to Hit Children', *The Telegraph*, Calcutta, February 4.

Mohanty Basant Kumar (2021a), 'Survey Starts to Fill Migrant Worker Black Hole', *The Telegraph*, Calcutta, April 1.

Murugai Rinku and Ravallion Martin (2005), 'Employment Guarantee in Rural India: What Would It Cost and How Much would It Reduce Poverty?', *Economic and Political Weekly*, 40 (31).

REFERENCES

- Narayanan Rajendran and De Anuradha (2021), 'The Long Road to Timely NREGA Payments', *The Hindu*, November 8.
- National Disaster Management Authority (2020), *COVID-19 Impacts and Responses: The Indian Experience*, January-May.
- National Health System Resource Centre (2011), ASHA: Which Way Forward ...? Evaluation of ASHA Programme, National Rural Health Mission, Accessed from https://nhm.gov.in/images/pdf/communitisation/asha/Studies/Evaluation_of_ASHA_Program_2010-11_Report.pdf on December 11, 2021.
- National Sample Survey Office (2014), *Drinking Water, Sanitation, Hygiene and Housing Condition in India, NSS 69th Round (July 2012 December 2012)*, NSS Report No. 556 (69/1.2/1), Ministry of Statistics and Programme Implementation, Government of India.
- National Statistical Office (2019): *Drinking Water, Sanitation, Hygiene and Housing Condition in India, NSS 76th Round (July 2018 December 2018)*, NSS Report no. 584 (76/1.2/1), Ministry of Statistics and Programme Implementation, Government of India.
- National Statistical Office (2020): *Health in India, NSS 75th Round (July 2017 June 2018)*, NSS Report no. 586/ (75/25.0), Ministry of Statistics and Programme Implementation, Government of India.
- Nawani N P (1994), *Indian Experience on Household Food and Nutrition Security*, Regional Expert Consultation, FAO-UN Bangkok (Thailand), Accessed from <http://www.fao.org/3/x0172e/x0172e00.htm#TopOfPage> on May 20, 2021.
- NCAER National Data Innovation Centre (2020), Delhi NCR Coronavirus Telephone Survey Round 1 (April 3-6): Preliminary Report, National Council of Applied Economic Research, Accessed from <https://ncaer.org/Image/Userfiles/File/Ndic-Tel/Dcvts%20results%202020-04-12-Final.Pdf> on December 20, 2020.
- PAEG (The People's Action for Employment Guarantee) (2020), PAEG Brief, July 13, *National Rural Employment Guarantee Act Implementation Tracker*, 2020.
- Palaiologos Yannis (2020), 'Economics Needs a Moral Awakening', www.ekathimerini.com Accessed on October 18, 2021.
- Pratichi Research Team (2020), 'COVID-19 and India's Unsung Frontline Health and Childcare Workers', *The Wire*, Available at <https://thewire.in/society/covid-19-india-frontline-health-workers>

Press Information Bureau (2020), *ASHA Workers*, Ministry of Health and Family Welfare, Government of India, Accessed from <https://pib.gov.in/Pressreleaseshare.aspx?PRID=1606212> on December 11, 2021.

Przeworski Adam and Frank Salomon (1988), *On the Art of Writing Proposals*, Social Science Research Council.

Raghunathan Kalyani, Headey Derek and Herforth Anna (2020), *Affordability of Nutritious Diets in Rural India*, IFPRI Discussion Paper 01912.

Raini Agrima (2020), 'Asha Workers Are Hailed as Covid Warriors but Only 62% Have Gloves, 25% Have No Mask', *The Print*, September 21, Accessed from <https://theprint.in/opinion/asha-workers-are-hailed-as-covid-warriors-but-only-62-have-gloves-25-have-no-masks/506623/> on December 19, 2021.

Rogaly B, Biswas J, Coppard D, Rafique A, Rana K, Sengupta A (2001), 'Seasonal Migration, Social Change and Migrants' Rights: Lessons from West Bengal', *Economic and Political Weekly*, 36 (49).

Roy Aruna, Dave Saba Kohli (2020): 'When People and Governments Come Together: Analysing Kerala's Response to the COVID-19 Pandemic', *Economic & Political Weekly*, 55 (18).

Roychowdhury Anamitra (2020) 'Labour Rights Are in Free Fall', *The Hindu*, May 18.

Rukmini S (2021) 'Gauging Pandemic Mortality with Civil Registration Data', *The Hindu*, July 6.

Sainath P (2020), 'What We Should Do about COVID-19', *People's Archive of Rural India*, March 27.

Sampath G (2020), 'The Migrant Workers as a Ghost among Citizens', *The Hindu*, November 25.

Sarkar Ashoke (2020), 'Kon Kajer Mulya Kawto?' (in Bengali) *Anandabazar Patrika*, December 24.

Sarkar Manabesh (2017), *Unqualified Medical Practitioners: Unavoidable for the Health Care of Rural People?* Pratichi Occasional Paper No. 5, Kolkata: Pratichi Institute, Pratichi (India) Trust.

Sen Amartya (1993), 'Capability and Well Being' in Nussbaum M and Sen A (eds.) *The Quality of Life*, Clarendon Press, Oxford.

Sen Amartya (1999), *Development as Freedom*, New York: Oxford University Press.

REFERENCES

- Shewade Hemant Deepak and Parameswaran Giridara Gopal (2020), 'COVID-19 Deaths May be Higher than Reported', *The Hindu*, August 10.
- SickKids and Centre for Global Child Health (2021), *Direct and Indirect Effects of the COVID-19 Pandemic and Response in South Asia*, UNICEF.
- Singhal Karan, Rajendra Advaita and Sarin Ankur (2021), 'Another Wave Spells More Nutrition Loss', *The Hindu*, April 27.
- Srinivasan Ramani and Radhakrishnan Vignesh (2021), 'Kolkata's COVID-19 Deaths in 2021 Could be 4 Times Higher', *The Hindu*, May 28.
- State Bureau of the Health Intelligence (No date), *Health on the March 2015-16: West Bengal (Draft Copy)*, Kolkata: Directorate of Health Services, Government of West Bengal.
- Sumner Andy, Ortiz-Juarez Eduardo and Hoy Chris (2020), *Precarity and the Pandemic: COVID-19 and Poverty Incidence, Intensity and Severity in Developing Countries*, UNU-WIDER Working Paper 77.
- Tharyan Prathap and John T Jacob (2020), 'A Shot of Hope with a Game Changing Vaccine', *The Hindu*, April 20.
- The Hindu (2021), *COVID-19 Led to Rise in Maternal Deaths, Stillbirth*, April 2.
- The Hindu Data Team (2021), 'Excess Deaths during the Pandemic in India was 5.8 Times the Official COVID-19 Death Toll', *The Hindu*, September 11.
- The Indian Express (2020), *Lockdown: Over 500 Cases of Child Marriages Reported since Mid-March in West Bengal*, June 29.
- The Telegraph (2021), *Child Marriages Spike in Lockdown around Bengal*, June 14.
- The Times of India (2020), 'MR Bangur Kolkata's first COVID-19 hospital, MCH plan dropped' April 4, Accessed from <https://timesofindia.indiatimes.com/city/kolkata/mr-bangur-citys-first-covid-hospital-mch-plan-dropped/articleshow/74975786.cms> on May 26, 2021.
- Thomas Isaac T M, Sadanandan Rajeev (2020), 'COVID-19, Public Health System and Local Governance in Kerala' *Economic & Political Weekly*, 55 (21).
- Thomas Mathew (2021), 'Rise in Child Marriages in the Lockdown: How the Centre Ignored Data of Its Own Nodal Agency', *The Wire*, April 8.
- UNDP (2009), *Human Development Report 2009*, New York: United Nations Development Programme.

United Nations (No date), *Transforming Our World: The 2030 Agenda for Sustainable Development*, A/RES/70/1, Accessed from <https://sustainabledevelopment.un.org/content/documents/21252030%20Agenda%20for%20Sustainable%20Development%20web.pdf> on December 21, 2021.

WHO (2020), *Novel Coronavirus (2019-nCoV): Situation Report 10*, Accessed from https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200130-sitrep-10-ncov.pdf?sfvrsn=d0b2e480_2 on April 06, 2021.

WHO (No date), *At Least 80 Million Children under One at Risk of Diseases such as Diphtheria, Measles and Polio as COVID-19 Disrupts Routine Vaccination Efforts, Warn Gavi, WHO and UNICEF*, Accessed from <https://www.who.int/news/item/22-05-2020-at-least-80-million-children-under-one-at-risk-of-diseases-such-as-diphtheria-measles-and-polio-as-covid-19-disrupts-routine-vaccination-efforts-warn-gavi-who-and-unicef> on November 11, 2021.

WHO and UNICEF (2020), *Water, Sanitation, Hygiene, and Waste Management for SARS-CoV-2, the Virus that Causes COVID-19: Interim Guidance*, Accessed from <https://www.who.int/publications/i/item/WHO-2019-nCoV-IPC-WASH-2020.4> on May 07, 2021.

William Joe, Kumar Abhishek, Rajpal Sunil, Mishra U S, and Subramanian S V (2020), 'Unequal Burden? Gender Differentials in COVID-19 Mortality in India', *Journal of Global Health Science*, 2(1).

Z. Ansari A A, Desai H D, Sharma K, Jadeja D M, Patel R, Patel Y, Desai H M (2021), 'Prevalence and Cross States Comparison of Case Fatality Rate and Recovery Rate of COVID-19/SARS-CoV-2 in India', *Journal of Family Medicine and Primary Care*, 10 (475-80).

Appendix Tables

Table A.1: Rural Urban distribution of households by access to latrine (in percent)

	Exclusively used	Shared with other households	Public/Community	Others	No latrine, open defecation	Total
Rural	79.1 (265)	4.5 (15)	0.6 (2)	2.1 (7)	13.7 (46)	100.0 (335)
Urban	77.6 (128)	9.7 (16)	12.1 (20)	0.6 (1)	0.0 (0)	100.0 (165)
All	78.6 (393)	6.2 (31)	4.4 (22)	1.6 (8)	9.2 (46)	100.0 (500)

(Figures in parenthesis indicate the absolute numbers)

Source: Pratichi primary survey 2020

Table A.2a: Rural Urban distribution of households by access to drinking water (in percent)

	Exclusively used	Shared with other households	Public/Community	Others	Total
Rural	35.2 (118)	3.9 (13)	58.5 (196)	2.4 (8)	100.0 (335)
Urban	37.6 (62)	7.3 (12)	50.9 (84)	4.2 (7)	100.0 (165)
All	36.0 (180)	5.0 (25)	56.0 (280)	3.0 (15)	100.0 (500)

(Figures in parenthesis indicate the absolute numbers)

Source: Pratichi primary survey 2020

Table A.2b: Rural Urban distribution of households by access to water for household activities (in percent)

	Exclusively used	Shared with other households	Public/Community	Others	Total
Rural	55.8 (187)	5.4 (18)	38.8 (130)	0.0 (0)	100.0 (335)
Urban	33.3 (55)	10.3 (17)	55.8 (92)	0.6 (1)	100.0 (165)
All	48.4 (242)	7.0 (35)	44.4 (222)	0.2 (1)	100.0 (500)

(Figures in parenthesis indicate the absolute numbers)

Source: Pratichi primary survey 2020

Table A.3a: Knowledge about symptoms of COVID-19 by social category of the respondents (in percent)

Symptoms	SC	ST	OBC	Others	All
Fever	93.0 (133)	76.8 (53)	98.6 (68)	95.0 (208)	92.4 (462)
Cough	89.5 (128)	78.3 (54)	95.7 (66)	91.3 (200)	89.6 (448)
Short Breathing	55.9 (80)	31.9 (22)	73.9 (51)	59.4 (130)	56.6 (283)
Fever & Cough	89.5 (128)	75.4 (52)	95.7 (66)	90.9 (199)	89.0 (445)
Fever, Cough & Short Breathing	53.8 (77)	30.4 (21)	71.0 (49)	57.1 (125)	54.4 (272)
Loose stool	14.7 (21)	0.0 (0)	11.6 (8)	16.9 (37)	13.2 (66)
Headache-Body ache-Throat inflammation	12.6 (18)	5.8 (4)	10.1 (7)	11.0 (24)	10.6 (53)
Others	7.0 (10)	2.9 (2)	2.9 (2)	10.5 (23)	7.4 (37)
No knowledge about symptoms	6.3 (9)	20.3 (14)	2.9 (2)	4.6 (10)	7.0 (35)
Sample size	143	69	69	219	500

(Figures in parenthesis indicate the absolute numbers)

Source: Pratichi primary survey 2020

Table A.3b: Knowledge about symptoms of COVID-19 by geographic region of the respondents (in percent)

Symptoms	Kolkata	South-East Bengal	South-West Bengal	North Bengal	All
Fever	95.3 (81)	96.1 (173)	85.8 (103)	91.3 (105)	92.4 (462)
Cough	90.6 (77)	92.8 (167)	85.0 (102)	88.7 (102)	89.6 (448)
Short Breathing	60.0 (51)	67.2 (121)	39.2 (47)	55.7 (64)	56.6 (283)
Fever & Cough	89.4 (76)	92.8 (167)	85.0 (102)	87.0 (100)	89.0 (445)
Fever, Cough & Short Breathing	54.1 (46)	65.0 (117)	39.2 (47)	53.9 (62)	54.4 (272)
Loose stool	29.4 (25)	9.4 (17)	0.8 (1)	20.0 (23)	13.2 (66)
Headache-Body ache-Throat inflammation	12.9 (11)	13.9 (25)	4.2 (5)	10.4 (12)	10.6 (53)
Others	3.5 (3)	15.0 (27)	2.5 (3)	3.5 (4)	7.4 (37)
No knowledge about symptoms	2.4 (2)	4.4 (8)	14.2 (17)	7.0 (8)	7.0 (35)
Sample size	85	180	120	115	500

(Figures in parenthesis indicate the absolute numbers)

Source: Pratichi primary survey 2020

Table A.3c: Knowledge about symptoms of COVID-19 by religion of the respondents (in percent)

Symptoms	Hinduism	Islam	Sarna/Sari	Others	All
Fever	92.5 (368)	97.5 (77)	77.8 (14)	60.0 (3)	92.4 (462)
Cough	89.7 (357)	93.7 (74)	77.8 (14)	60.0 (3)	89.6 (448)
Short Breathing	56.0 (223)	64.6 (51)	38.9 (7)	40.0 (2)	56.6 (283)
Fever & Cough	88.9 (354)	93.7 (74)	77.8 (14)	60.0 (3)	89.0 (445)
Fever, Cough & Short Breathing	53.5 (213)	63.3 (50)	38.9 (7)	40.0 (2)	54.4 (272)
Loose stool	15.3 (61)	6.3 (5)	0.0 (0)	0.0 (0)	13.2 (66)
Headache-Body ache-Throat inflammation	10.3 (41)	13.9 (11)	5.6 (1)	0.0 (0)	10.6 (53)
Others	8.0 (32)	5.1 (4)	0.0 (0)	20.0 (1)	7.4 (37)
No knowledge about symptoms	6.5 (26)	3.8 (3)	22.2 (4)	40.0 (2)	7.0 (35)
Sample size	398	79	18	5	500

(Figures in parenthesis indicate the absolute numbers)

Source: Pratichi primary survey 2020

Table A.3d: Knowledge about symptoms of COVID-19 by households' highest educational level of the respondents (in percent)

Symptoms	Illiterate	Below Primary	Primary 91-5)	Upper Primary	Secondary	Higher Secondary	Graduate	Post Graduate and above	Others	All
Fever	66.7 (4)	63.6 (7)	81.6 (40)	89.1 (114)	95.5 (84)	96.7 (87)	98.0 (100)	100.0 (24)	100.0 (2)	92.4 (462)
Cough	66.7 (4)	54.5 (6)	77.6 (38)	85.9 (110)	93.2 (82)	94.4 (85)	96.1 (98)	95.8 (23)	100.0 (2)	89.6 (448)
Short Breathing	33.3 (2)	45.5 (5)	36.7 (18)	49.2 (63)	53.4 (47)	67.8 (61)	68.6 (70)	66.7 (16)	50.0 (1)	56.6 (283)
Fever & Cough	66.7 (4)	54.5 (6)	77.6 (38)	84.4 (108)	93.2 (82)	94.4 (85)	95.1 (97)	95.8 (23)	100.0 (2)	89.0 (445)
Fever, Cough & Short Breathing	33.3 (2)	36.4 (4)	34.7 (17)	46.1 (59)	52.3 (46)	65.6 (59)	66.7 (68)	66.7 (16)	50.0 (1)	54.4 (272)
Loose stool	0.0 (0)	0.0 (0)	8.2 (4)	15.6 (20)	15.9 (14)	7.8 (7)	15.7 (16)	20.8 (5)	0.0 (0)	13.2 (66)
Headache-Body ache-Throat inflammation	0.0 (0)	0.0 (0)	20.4 (10)	10.9 (14)	5.7 (5)	10.0 (9)	11.8 (12)	12.5 (3)	0.0 (0)	10.6 (53)
Others	0.0 (0)	0.0 (0)	0.0 (0)	5.5 (7)	3.4 (3)	4.4 (4)	16.7 (17)	25.0 (6)	0.0 (0)	7.4 (37)
No knowledge about symptoms	50.0 (3)	36.4 (4)	18.4 (9)	8.6 (11)	4.5 (4)	3.3 (3)	1.0 (1)	0.0 (0)	0.0 (0)	7.0 (35)
Sample size	6	11	49	128	88	90	102	24	2	500

(Figures in parenthesis indicate the absolute numbers)

Source: Pratichi primary survey 2020

Table A.4a: Knowledge of precautionary measures for the protection from COVID-19 by social category of the respondents (in percent)

Measures for protection	SC	ST	OBC	Others	All
Wearing masks or covering mouth/nose with handkerchief etc	98.6 (141)	91.3 (63)	97.1 (67)	97.7 (214)	97.0 (485)
Physical distancing	64.3 (92)	66.7 (46)	68.1 (47)	71.7 (157)	68.4 (342)
Hand wash with soap or sanitizer	94.4 (135)	63.8 (44)	95.7 (66)	92.7 (203)	89.6 (448)
Others	16.1 (23)	14.5 (10)	11.6 (8)	16.0 (35)	15.2 (76)
No knowledge about precautionary measures	0.7 (1)	4.3 (3)	0.0 (0)	1.4 (3)	1.4 (7)
Sample size	143	69	69	219	500

(Figures in parenthesis indicate the absolute numbers)

Source: Pratichi primary survey 2020

Table A.4b: Knowledge of precautionary measures for the protection from COVID-19 by religion of the respondents (in percent)

Measures for protection	Hinduism	Islam	Sarna/Sari	Others	All
Wearing masks or covering mouth/nose with handkerchief etc	97.7 (389)	97.5 (77)	83.3 (15)	80.0 (4)	97.0 (485)
Physical distancing	66.6 (265)	75.9 (60)	77.8 (14)	60.0 (3)	68.4 (342)
Hand wash with soap or sanitizer	91.5 (364)	94.9 (75)	27.8 (5)	80.0 (4)	89.6 (448)
Others	16.8 (67)	6.3 (5)	22.2 (4)	0.0 (0)	15.2 (76)
No knowledge about precautionary measures	1.0 (4)	1.3 (1)	5.6 (1)	20.0 (1)	1.4 (7)
Sample size	398	79	18	5	500

(Figures in parenthesis indicate the absolute numbers)

Source: Pratichi primary survey 2020

Table A.4c: Knowledge of precautionary measures for the protection from COVID-19 by households' highest educational level of the respondents (in percent)

Measures for protection	Illiterate	Below primary	Primary (1-5)	Upper Primary	Secondary	Higher Secondary	Graduate	Post Graduate and above	Others	All
Wearing masks or covering mouth/nose with handkerchief etc	66.7 (4)	90.9 (10)	93.9 (46)	98.4 (126)	97.7 (86)	95.6 (86)	99.0 (101)	100.0 (24)	100.0 (2)	97.0 (485)
Physical distancing	50.0 (3)	36.4 (4)	69.4 (34)	71.1 (91)	65.9 (58)	70.0 (63)	66.7 (68)	83.3 (20)	50.0 (1)	68.4 (342)
Hand wash with soap or sanitizer	50.0 (3)	72.7 (8)	83.7 (41)	91.4 (117)	88.6 (78)	91.1 (82)	93.1 (95)	95.8 (23)	50.0 (1)	89.6 (448)
Others	33.3 (2)	18.2 (2)	12.2 (6)	10.9 (14)	11.4 (10)	20.0 (18)	15.7 (16)	29.2 (7)	50.0 (1)	15.2 (76)
No knowledge about precautionary measures	16.7 (1)	9.1 (1)	4.1 (2)	0.8 (1)	1.1 (1)	1.1 (1)	0.0 (0)	0.0 (0)	0.0 (0)	1.4 (7)
Sample size	6	11	49	128	88	90	102	24	2	500

(Figures in parenthesis indicate the absolute numbers)

Source: Pratichi primary survey 2020

Table A.5: Reported practice of public health measures for the protection from COVID-19 by rural-urban background of the respondents (in percent)

Precautionary measures following	Rural	Urban	All
Wearing masks or covering mouth/nose with handkerchief etc	90.4 (303)	97.6 (161)	92.8 (464)
Physical distancing	54.9 (184)	44.8 (74)	51.6 (258)
Hand wash with soap or sanitizer	78.2 (262)	96.4 (159)	84.2 (421)
Others	20.7 (70)	17.6 (29)	19.8 (99)
Not following any precautionary measures	5.7 (19)	0.6 (1)	4.0 (20)
Sample size	335	165	500

(Figures in parenthesis indicate the absolute numbers)

Source: Pratichi primary survey 2020

Table A.6: Distribution of persons visited for medical treatment for non-hospitalized cases of illness by type of facility and periods of treatment (in percent)

Type of facility	During lockdown	During unlock	All
Government or Public facilities (Primary Health Centre / Corporation Health Centre/Govt. Hospital)	33.3 (9)	16.9 (27)	19.3 (36)
Private Allopathic Doctors (Chamber/Clinic or Hospital)	22.2 (6)	26.9 (43)	26.2 (49)
Private Homeopathy Doctor	11.1 (3)	1.9 (3)	3.2 (6)
Private Telemedicine	0.0 (0)	3.8 (6)	3.2 (6)
Unqualified Medical Practitioner	11.1 (3)	23.8 (38)	21.9 (41)
Medical Store / Self treatment	14.8 (4)	17.5 (28)	17.1 (32)
Others	0.0 (0)	3.1 (5)	2.7 (5)
No treatment	7.4 (2)	6.2 (10)	6.4 (12)
Total	100.0 (27)	100.0 (160)	100.0 (187)

(Figures in parenthesis indicate the absolute numbers)

Source: Pratichi primary survey 2020

